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EXAMINATION OF QUALITY OF CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

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BEFORE THE

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UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

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EXAMINATION OF QUALITY OF CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

TUESDAY, JUNE 3, 1986

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee was convened, pursuant to notice, at 9:35 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger presiding.

Present: Senators Durenberger, Chafee, Heinz, Symms, Grassley, Baucus, and Mitchell.

[The press release announcing the hearing and the prepared statements of Senators Packwood and Heinz follow:]

[Press Release No. 86-045]

FINANCE COMMITTEE TO EXAMINE QUALITY OF CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

The Senate Committee on Finance will examine the issue of whether or not the quality of health care for older Americans has changed as a result of Medicare's prospective payment system, Chairman Bob Packwood (R-Oregon) announced today.

Senator Packwood said the hearing would begin at 9:30 a.m., Tuesday, June 3, 1986, in Room SD-215 of the Dirksen Senate Office Building.

Senator Packwood explained that the Medicare prospective payment system was implemented in conjunction with a number of safeguards designed to protect the quality of health care. "I am gravely concerned about allegations that because of the prospective payment system, Medicare beneficiaries are being released from hospitals before their need for acute inpatient care has been met. I also am concerned about patients who are discharged without an appropriate plan for their post-hospital care, and about reports that post-hospital services, such as skilled nursing facility and home health care may not be available."

Senator Packwood stated that he is aware of the incentives and potential for premature discharges. "If the data is not available to demonstrate a problem, the potential certainly exists. The purpose of this hearing is to examine what is known about the extent or potential for premature discharges, to examine the existing safeguards, and to solicit views on what changes might be made to assure that Medicare beneficiaries are not denied quality health care."

The Chairman said the Committee expects to receive testimony from representatives of the hospital industry, peer review organizations, the research community, and beneficiary representatives.

Senator Packwood also noted that witnesses and others should take the opportunity to provide their views on a recently proposed bill to address the quality problem—S. 2331, "The Medicare Quality Protection Act of 1986", sponsored by Senator John Heinz (R-Pennsylvania) and others.

OPENING STATEMENT OF SENATOR BOB PACKWOOD

We are here this morning to examine a matter of considerable interest to me and to other members of the Finance Committee—the status of health care under the prospective payment system and whether or not Medicare beneficiaries are receiving high quality care under the new system. I have convened this hearing to review the facts and the available data behind allegations that Medicare's perspective payment system has caused beneficiaries to be prematurely discharged from some hosptials before they are medically ready and able to leave. Concerns also have been expressed that Medicare beneficiaries do not have adequate access to post-hospital care services, such as nursing home care or home health visits, because the hospital either failed to develop an adequate discharge plan, or because Medicare's payment rules for post-hospital care do not accommodate a health delivery system that now emphasizes cost-effective outpatient care.

In 1983, health care costs were out of control and the Medicare trust fund was on the verge of bankruptcy. We took a hard look at the problem then, and decided that we would eliminate the "fat" in the hospital payment system. Thus, we passed legislation creating the prospective payment system. Under PPS, we gave hospitals a financial incentive to avoid unnecessary services and to lower costs. We knew that hosptials, in conjunction with physicians, should make decisions on which services were necessary and which were not. As a result, there have been a lot of changes. For example, under the old cost system, a patient might have been admitted to the hospital a day or two early in order to "rest-up" before his or her treatment. Another patient might stay an extra day or two after his or her treatment until it was more convenient to go home. Under PPS, these types of medically unnecessary and what some have called "social" hospital days, are no longer reimbursed as acute inpatient services. We also know that before PPS, physicians could order any medical test or procedure, including surgery, whether or not it was needed. Often these services involved unnecessary risk to the patient. Now, physicians are being asked to order only those services that are necessary for the patient's diagnosis, treatment, and recovery. Do these changes lower quality care or merely alter the type of care to which patients have been accustomed? Other system changes that have been made and the impact of these changes on the Medicare patient's health either in the hospital or after discharge need to be explored.

When Congress enacted the PPS legislation, we intended the system to efficiently and effectively deliver medically appropriate and necessary care of high quality. However, we also recognized that there were incentives inherent in the system that had the potential to increase hospital and physician revenues at the patient's expense. Congress therefore built in a number of safeguards to assure that Medicare beneficiaries were protected from potential abuses. These included special payment provisions for complex cases, independent review through peer review organizations, and special reporting to Congress.

Today, we will examine whether these safeguards are working. Are the problems that we hear about due to the transition to a new payment system? Or is there a flaw in the system that we had not anticipated? If modifications are required, we want to make the necessary adjustments. If new safeguards are required we want to make the necessary additions.

Today, we ask our witnesses for specifics. We want to know whether or not patients are being admitted or readmitted to a hosptial appropriately; whether or not access to necessary medical care has changed; whether or not tests and procedures are adequate; whether or not discharges are premature; and whether appropriate post-hospital services are available. If there is a problem, we want to know how widespread it is and how it is distributed across payment categories, patients, and geographic areas. Further, I want your recommendation on how the problem can be fixed. If data on the problem is not yet available, I want to know how we can protect beneficiaries in the interim. Your comments also will be welcome on the provisions in S. 2331, the Medicare Quality Protection Act of 1986, introduced by Senator Heinz.

Unfortunately, because of my involvement with the tax reform bill, I will be unable to remain here this morning to hear the evidence presented. The tax bill is at a very critical stage in the legislative process. It offers important benefits for Medicare beneficiaries, as well as all Americans, such as simplification and lower tax rates. Since we will soon debate the bill on the Senate floor, I have asked Senator Durenberger, who is the chairman of the Subcommittee on Health, to chair the hearing this morning. Senator Durenberger's interest in assuring that Medicare beneficiaries receive high quality health care goes back a long way. He was instrumental in developing legislation to establish Peer Review Organizations, or PROs, whose job it is to monitor quality of care under the Medicare program.

I want to thank each of the witnesses here for sharing their perspective and knowledge on this important issue. I have asked the staff to consider the provisions in S. 2331 as well as the bill Senator Durenberger intends to introduce next week, in order, to produce a package of proposals for the committee's consideration.

STATEMENT OF DAVE DURENBERGER

The federal government's commitment to health care has traditionally centered around the twin national objectives of assuring access and quality for all Americans. Twenty years ago, Congress established Medicare as a way of delivering on that commitment for this country's elderly and disabled.

But, in 1966, our definition of "quality" was quite different from today. In fact, by today's standards, access was given much greater emphasis than quality in a system often characterized by long stays in the hospital, and patients who were examined, but not treated, and cared for, but not cured.

In the last twenty years, however, advances like intensive care units, and amazing new diagnostic tools, pacemakers, by-pass surgery, cancer therapies, and same day cataract operations, have changed the definition of quality medical care for all Americans.

For the elderly and disabled in particular, the hospital is no longer simply a place to convalesce or to die. Now, thanks to advances in medical science, the hospital can be a place to renew, and even improve, life.

With all these advances in modern medicine, however, have come new challenges. New, more expensive procedures and devices—when combined with Medicare's financing arrangements resulted in better access to effective care for beneficiaries, but also tremendous increases in cost for both beneficiaries and the American taxpayer.

The Medicare "money machine" very naturally lead doctors, hospitals, and their patients to think that "more medicine" was automatically "better medicine."

Eventually, concern arose among many Americans that the "more is better" practice standard was not only too costly, but might also mean "too much" medicine, particularly in the case of expensive hospital services.

These concerns led to a traditional regulatory response on the part of government with "Certificate of Need" legislation and the genesis of the Professional Standards Review Organization (PSRO) program, and, later, the Peer Review Organizations (PROS) which I helped to develop.

Action on the regulatory side, though, was only part of the answer. Payment reform had to be the major driving force to bring incentives for the providers in line with the actual needs of the beneficiaries. The advent of the per case pricing for hospitals in 1983—payment by Diagnosis Related Groups (DRGs)—replaced the traditional cost-based payment system and brought with it a "new day" in hospital care for Medicare and the millions of Americans it serves.

Now, instead of "more is better," the new Medicare payment system sends doctors and hospitals a signal that patient care should be managed carefully and that patients should receive only that care which they need.

These significant reforms are working largely as intended. Hospitals and other providers have responded well. The new system has given the Medicare hospital trust fund billions of dollars in savings and has given efficient hospitals the ability to make profit margins necessary to maintain financial viability.

While the signals of the new Medicare payment system have been clear to hospitals and doctors, they have not been as clear to elderly and disabled Medicare beneficiaries. Many patients have been confused about what "quality" can mean when they are directed away from traditional hospital settings for treatment or discharges after what seems like very short hospital stays. And, many older Americans are concerned that the new payment system leaves the potential for providers to "short-sheet' patients on quality.

These concerns have led at least some older Americans to conclude that they may be worse off under the new Medicare involved with the "more is better" philosophy of the past, we must now confront the risks of an approach which seems to be saying that "less is better."

The Finance Committee—and its Health Subcommittee—are indebted to our distinguished colleague Senator John Heinz and his Select Committee on Aging for the very appropriate leadership they have taken in monitoring the reaction of elderly Americans to changes in doctor and hospital behavior as a result of the new Medicare payment system.

These and other concerns which have been raised about the effect on quality of recent Medicare changes are at the heart of today's hearing. To put it quite bluntly, we want to know whether and to what extent hospitals are "short-sheeting" elderly patients.

One often-cited indicator of lower quality is the estimated three to four thousand premature discharges of Medicare patients identified since 1983. Witnesses this morning will report differing interpretations of the early discharge issue. And, I'm sure we will hear some discussion and debate about how high or low the actual number of these early discharges really is. But, we must be careful to sort out the extent to which early discharges actually reflect a systematic reduction in quality of care for Medicare patients.

The hearing will, therefore, focus on three critical issues:

First, are these three to four thousand early discharges the tip of a "quicker and sicker" iceberg? Or, are they exceptions to the rule of generally good medical practice? Do we even have the ability to answer this question? Can we, in other words, answer, with facts, this critical question?

Second, how much of the concern over premature hosptial discharges can be attributed to the fact that DRGs changes the practice of medicine overnight, while all of us forgot to tell the beneficiaries?

Before 1983, Medicare patients could expect to stay in a traditional hospital setting until they were completely recovered. This meant that many hospital stays included what one might call "social days,": or days during which the patient didn't actually require acute care, but couldn't arrange for, or afford, the less intense post-hospital care actually needed. So, the patient stayed in the hospital and the hospital sent the total bill—including the cost of the "social days"—to Medicare's hospital trust fund.

Now, however, hospitals have no incentive to encourage either inappropriate admissions or longer-than-necessary stays. And PROs won't allow either. Medicare now pays hospitals only to care for people who actually need hospital care not for people who can and should be treated in less expensive, but still very appropriate settings.

Thousands of older Americans, for example, are having cataract and other types of surgery in same-day surgery centers. And thousands more receive cancer fighting chemotherapy treatments in outpatient departments and, increasingly, in their own homes. All Americans are having to get used to these kinds of changes in the practice of Medicine. Mothers no longer spend five days in the hospital "resting up" after the birth of a baby. And dozens of tests and other procedures which used to require hospitalization are now done, routinely, in doctors' offices all over America.

Third, how much of the concern over premature hospital discharge is really a concern over patients' inability to find the non-hospital settings or post-hospital care they need?

As I have said, Medicare's new payment system means that patients will be admitted to hospital only when hospitalization is needed and discharged from the hospital as soon as hospitalization is no longer necessary.

In the days of cost-based reimbursement, Medicare paid the cost of convalescent care when it paid for all the hospital days the doctor ordered. Now, however, Medicare has made it clear that his type of care must be provided outside the expensive hospital setting. Yet, Medicare hasn't changed its post hospital care structure.

This leads one to logically ask the question "Should Medicare now pay more of the share of post-hospital care—particularly since the burden of that care has now increased?'

My tentative answer to that question is "yes," but we haven't yet conformed the payment systems for nursing home, home health and other alternatives to ease the burden of choice on the patient and the doctor.

As I read the testimony that was submitted for this hearing either these three issues in mind, I was struck by the work of the General Accounting Office and the Office of Technology Assessment. Those two agencies did not conclude that there was a quality problem. But, they don't conclude that there was not a quality problem, either.

Instead they concluded that there is—amazingly enough—no date with which to tell whether there is a quality problem with the new Medicare payment system.

That conclusion leads me to call for a united effort to get the information we all need to really answer the questions asked by today's hearing. I understand that Blue Cross/Blue Shield is establishing a nationwide, computerized information-sharing network which will cover 80 million patients. I'm sure there is much the federal government can learn from this kind of national health data network.

In a letter to Secretary Bowen, Senator Heinz and I have already expressed concerns about specific problems with the administration and organization of Medicare data which inhibits its usefulness in evaluation of the effects of major policy changes on Medicare beneficiaries.

Similarly, to my knowledge, HCFA has made no systematic effort to create a usable PRO research data base. Therefore, PROs do not perform their reviews in a way which allows the data to be analyzed to identify regional variations in treatment patterns or to conduct national evaluations using objective measures of quality of care.

In order to begin to remedy this situation, I intend to introduce next week legislation which should help fill the critical gaps in our current knowledge of the needs of Medicare beneficiaries and the quality of care they are receiving.

That legislation, the "Medicare Information Act of 1986" will implement several of OTA's recommendations and those we hear today for improving the usefulness of existing and future Medicare information.

This legislation will create a new Medicare "Quality Barometer System"—or QBS— to provide both administrators and policy-makers with the kind of information they need to address the issue of quality of care without dependence on anecdotes and estimates.

And, this legislation will take a longer view, beyond the immediate quality questions raised by DRGs. It will help Medicare to buy value for its beneficiaries, by establishing a program to study the health outcomes of Medicare patients who undergo procedures for which utilization varies. Such studies are essential if we are to understand better how to determine which and what level of care is really the "best" care.

Finally, I'd like to take this opportunity—while representatives of all segments of the health care delivery system are together here—to remind all of us that "quality" isn't an issue which can be resolved by one hearing or by one bill or regulation.

A reporter asked me the other day if I had introduced any "quality" bills. My answer was that every bill I have authored addressing health care" reform is a patient "quality of care" bill. Making sure that health care is more cost effective means getting better quality through wiser use of financial and medical resources.

But, in meeting this obligation, hospitals and doctors can't be "short-sheeted" any more than patients.

Ensuring quality care, in other words means making sure that money isn't arbitrarily taken out of payments to hospitals for capital or physicians' fees. And, it means that hospitals and physicians must be given the correct economic signals to protect quality of care for beneficiaries.

Across-the board freezes and uniform DRG adjustments that fall way below increases in costs are not consistent with meeting this obligation to ensure quality.

We are fortunate to have with us today a distinguished set of witnesses to help us explore both concerns about the effect of the current Medicare payment system on quality and the adequacy of present information sources in answering that critical question.

STATEMENT OF SENATOR JOHN H. CHAFEE

Mr. Chairman, ever since the prospective payment system was enacted three years ago, I have received mixed reviews on its effects. Today's hearings are a critical step in the process of looking at the program and deciding what our next steps should be.

One of the most compelling reasons we decided to develop PPS was our acute concern about the rapidly increasing cost of health care and especially the continued escalation in the cost of the Medicare Program. There is no doubt that the new system has been effective in containing the cost of Medicare. However, our zeal in containing costs must be balanced against our concern about maintaining the quality of health care for senior citizens.

The hearing today is a first step in assessing these problems. Some of the questions that must be explored include:

1. Are Medicare beneficiaries being discharged from the hospital too soon?
2. Is there adequate post-hospital planning for those patients needing home health care services or more intensive services in skilled nursing facilities?
3. Has early discharge increased the financial burden to beneficiaries?

These are serious and troubling questions.

I have already cosponsored a variety of legislation which addresses some of these problems. Most recently, I have joined with Senator Heinz and others in support of "the Medical Quality Protection Act of 1986", S. 2331, which is designed to improve the quality of hospital services under PPS and ensure greater access to post-hospital services. Of particular importance is the requirement for hospitals to provide discharge planning to ensure the continuity of patient care. This bill also addresses the need for oversight of quality by strengthening the systematic surveillance of hospitals and expands the scope of the present peer review organization to post-hospital care in home health agencies and nursing homes.

This legislation begins to address the problems we are here to explore today. However, this is only the first step in tackling the much bigger problems which will confront us in the future.

One of the most troubling of these is long-term care. I am convinced that the most frightening concern of elderly individuals is that they will not have adequate financial support for health care services—especially long-term care—as they grow older. Currently, we have no systematic coverage to help patients with the catastrophic costs of long-term care—neither Medicare or private insurance provide financial assistance for these needs. Patients must deplete all resources and become impoverished before qualifying for the only available long term care assistance—Medicaid. We must devise alternatives to Medicaid, drawing on both private and public resources, to help pay for long-term care and prevent the elderly from facing poverty due to medical costs.

I hope that today's assessment of the PPS system will help us develop a response to long-term care needs, as well as improve the quality of care.

STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman, I am pleased to have the opportunity to testify today on the impact of Medicare's prospective payment system on quality of care. Assuring the quality of care received by our nation's senior citizens surely must rank as one of this Committee's highest priorities, and I commend you and Senator Packwood for holding this hearing.

The Senate Special Committee on Aging, which I am honored to chair, has conducted a lengthy and intensive investigation of quality of care under Medicare's prospective payment system. Now three years into PPS, it is evident that problems with quality—as well as access—are emerging, problems that demand our immediate attention and response.

I'd like to share with you just two examples from among the thousands of cases of quality abuse uncovered during the Aging Committee's 16-month investigation. We learned of an 85-year-old woman, discharged from a hospital after 12 days because her "Medicare coverage was up." She was sent to a substandard nursing home against her doctor's orders and against her family's wishes, where she died within 14 hours. Two days later, the family received a letter informing them of their rights to appeal the discharge.

The second case involves a 75 year old woman who was in a car accident in which her car was totalled. She was denied admission to the hospital and sent home with instructions that she should wake herself every four hours to make sure she hadn't suffered a concussion, even though she lived alone. The fact that these cases, and other like them, happen under our federal health care system is simply unacceptable.

My concerns about problems developing under prospective payment led me to introduce S. 2331, the Medicare Quality Protection Act, on April 17. Representative Pete Stark, Chairman of the Ways and Means Subcommittee on Health, introduced the indentical, companion bill (H.R. 4638) in the House. Broad, bipartisan support for the legislation is reflected in the many cosponsors that it has attracted on both sides of the Hill, including five other members of this Committee. S. 2331 is also supported by a wide range of senior advocate and provider groups, including the American Association of Retired Persons, the American Society of Internal Medicine, the American Nurses Association, the National Council of Senior Citizens, and the National Association of Home Care.

The purpose of the Medicare Quality Protection Act is to improve quality in hospital and post-hospital settings and ensure greater access to post-hospital services. The bill does not seek to dismantle PPS; nor does it impose a new layer of red tape and burdensome regulation on providers. On the contrary, it darns holes and repairs flaws in existing Medicare and Medicaid laws, strengthening quality and access to care while continuing to provide for effective Medicare cost containment.

In 1983, Congress acted to save a financially strappd Medicare program with the Prospective Payment System. We had confidence that this new reimbursement method could halt spiralling hospital cost and restore solvency. The good news is that our confidence has been rewarded. Hospital costs in 1985 increased by only 6 percent—the lowest rate of increase in the past 20 years.

But Congress also recognized that PPS contained certain inherent incentives to cut back on the level and quality of care provided patients. So Congress charged the Peer Review Organizations with the responsibility of monitoring quality and sanctioning providers who place high profits above good medical practice.

The bad news is that within a year of implementation, many physicians and consumers expressed concern that PPS did indeed pose a serious threat to quality of care for Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

These concerns, and evidence presented by the GAO, led the Senate Aging Committee to begin a lengthy and detailed investigation of quality and care problems developing under PPS. Time does not permit me to describe the nature of this investigation or the evidence uncovered. Let me just state that the Committee found that quality of care problems are widespread. Our most disturbing evidence showed that:

Hospitals are pressuring doctors to keep ill people out of the hospital and to discharge others in an unstable condition;

Patients and their families often receive false and incomplete information regarding their rights under the new payment system;

PROs have only a snapshot picture of quality and feel hamstrung by a "restrictive, underfunded, inflexible and narrowly-focused" review program; and

Too often, patients are discharged to an inappropriate setting for follow-up care.

Almost one-third of the nation's skilled nursing facilities are substandard, having failed to meet at least one basic Federal standard to assure the health and safety of nursing home residents. There has been a dramatic increase in the number of nursing homes cited for violating federal standards, signaling alarming quality of care problems for many of our 2 million nursing home residents, and

HHS and HCFA have failed to collect the type of data necessary to assess the extent to which PPS is having harmful effects on quality and access to care.

This last issue was most systematically revealed in a GAO study which I am happy to be able to release today. I am pleased that its principal author, Eleanor Chelimsky, has been invited to testify today, and I look forward to hearing what she has to say about assessing quality of care.

Mr. Chairman, I believe that the Medicare Quality Protection Act provides a major step forward in solving these serious quality of care problems. It makes needed adjustments in Medicare's hospital prospective payment system and the peer review process to improve quality of care in acute and post-acute facilities. It also improves Medicare patients' access to needed post-hospital care, protects and expands patients' rights in hospitals, and improves coordination among these federal agencies responsible for the health care of our nation's elderly.

The quality abuses documented under the DRG system cannot be halted without a comprehensive strategy for reform. We in the Congress have but one priority in this effort: to restore public confidence in the system and assure quality health care. The Medicare Quality Protection Act is designed with this priority in mind.

The Congressional Budget Office has estimated that our bill will cost a mere $200 million over the next three years. This is a small price to pay to ensure quality of care, especially when we consider that, over that same time period we're likely to spend more than $200 billion on the Medicare program as a whole. The prospective payment system, which is a partial cause of quality problems, is saving the Medicare program between $3 billion and $4 billion every year. Thus, spending less than $70 million a year is a worthwhile investment for protecting the quality of care under that system.

A summary of the major findings of the Senate Special Committee on Aging and the key provisions of the Medicare Quality Protection Act follow in the rest of my written statement that I ask be included in the record. I also request that copies of the staff reports from the three hearings the Senate Special Committee on Aging held last fall on this issue be included in the hearing record.

Mr. Chairman, it is important that we keep in mind, as we discuss this legislation, that while it takes us a good part of the way towards ensuring that patients continue to receive the very best health care possible under the Medicare program, much more still needs to be done. Substantial problems in quality of care still exist in the long term and post-hospital side of the health care system. As the second part of my answer to ensuring quality of care for Medicare and Medicaid recipients, I will soon introduce a bill that will propose solutions to the very serious quality of care problems that exist in those settings. I hope I can count on your support, and the support of the many distinguished colleague on both sides of the Hill who cosponsored the Heinz-Stark Medicare Quality Protection Act, in ensuring that quality of care exists in the full circle of federal health care programs.

I look forward to our continued efforts toward bringing the Medicare Quality Protection Act to passage and I thank you for convening this hearing.

PROTECTING QUALITY IN ACUTE CARE SETTINGS

(1) Refining the DRGs: Under PPS, patients deemed "DRG losers" by doctors and hospitals—patients with multiple serious conditions—are being prematurely discharged, inappropriately transferred, or refused admission for care. The problem is that DRGs reimburse based on average cost for a principle diagnosis, with no flexibility in payment to account for so-called differences in "severity of illness" among patients with the same diagnosis. Such an inequitable standard for payment encourages treatment of the straightforward case and the younger patient over treatment of the heavy care and older patient.

The Heinz-Stark bill requires HHS by January 1, 1988, to develop a PPS patient classification system that reflets variations in severity of illness and case complexity among patients within each diagnosis related group (DRG). HHS would also be required to consider possible changes in outlier policy as an alternative method of accounting for variations in severity and complexity.

2. Inadequate Rights of Appeal: The Aging Committee's investigation revealed that many patients who may wish to present evidence of substandard care or challenge a hospital discharge decision are unaware of their right of appeal, or are given false or incomplete information regarding this right. ProPAC also identified this as a problem in its 1986 Report to HHS and Congress.

At a hearing last fall of the Committee, one witness spoke of the anguish of having to watch her 85-year-old mother be discharged to a substandard nursing home against the doctor's orders and the family's wishes after a 12-day stay in the hospital for two heart attacks and a stroke. Carol Mahla's mother died within a day of being transferred. Two days later, the family received a letter informing them of their rights to appeal the discharge.

Mrs. Mahla's story is not unique. Under pressure from the Senate Aging Committee and consumer organizations, HHS recently improved patient notification procedures by requiring hospitals to provide notice of rights upon admission. But this notice stops short of ensuring that patients will be informed of their rights in a way that is clear and understandable. Current regulations, moreover, give hospitalized patients 48 hours to appeal a discharge before they can be held legally liable for any additional billings. Yet the PROs have three working days to respond to the appeal. This leaves the beneficiary at financial risk of having to pay out-of-pocket for one or more days of hospital care while awaiting a decision from the PRO.

The Medicare Quality Protection Act both improves patient notification and reduces the risk of accumulating out-of-pocket costs for hospital care while awaiting a decision from the PRO. First, HCFA would be required to grant beneficiaries 3 calendar days for appeal after receiving written notification of discharge before they begin to incur liability for a continued stay. Second, PROs would be required to decide appeals of continued stay denials within the same timeframe—3 calendar days.

Finally, in cases where the hospital serves a written notice of discharge but does not express intent to bill for a continued stay, the patient will be granted this same right to appeal. This extension of the appeal right plugs a loophole in the law which often results in the hospital telling patients to leave without informing them they can appeal the discharge decision.

3. Prohibit Incentives or "Kickbacks" that Potentially Lead to Reduced Care: At seven hospitals operated by the Paracelsus Health Care Corporation of Pasadena, California, doctors receive bonuses if costs are kept within DRG range. Similar programs elsewhere in the country also provide a one-to-one compensation of the physician for discharging a patient early. By creating a direct monetary incentive to reduce care, this new form of kickback threatens the well-being of Medicare patients. Current Medicare fraud and abuse law does not address this problem.

The Heinz-Stark bill specifically prohibits physician incentive plans that involve a payment for meeting specific per-case length-of-stay or cost targets. Violators of this provision would be subject to a civil monetary penalty. Additionally, the bill requires HHS to develop legislative recommendations by July 1, 1987 to prohibit or regulate other plans that have the effect of pressuring physicians to discharge patients prematurely or to reduce medically appropriate services.

4. Preserving Existing Quality Protections: The Aging Committee's investigation revealed substantial shortcomings in the existing quality assurance standards under both the Joint Commission for Accreditation of Hospitals and the Medicare Conditions of Participation. Yet even these limited protections face dilution by HHS' proposed revisions of the hospital "Conditions of Participation."

This bill requires that within two years of its enactment, HHS must submit to Congress a study concerning the adequacy of exisiting quality assurance standards for participating hospitals, including but not limited to consideration of the effect of changes in reimbursement policy since 1982. This provision would send a strong signal to HHS to hold off any regulations that might significantly weaken quality assurance requirements, while the Department examines ways to improve these requirements in the future.

II. IMPROVING ACCESS TO POST-HOSPITAL CARE

DRGs drive patients out of hospitals quicker and sicker. This finding is not dangerous in and of itself, since days-of-stay often exceeded what was medically necessary under the old system. But sicker and quicker can be hazardous when combined with the fact that post-hospital services are strained by the burden of more patients needing greater levels of care. For some Medicare beneficiaries, post-hospital care is unavailable or substandard.

The fact that the stress on post-hospital services is substantially increasing was confirmed by the General Accounting Office and by dozens of post-hospital care providers interviewed by the Senate Aging Committee's staff. These witnesses testified that more and sicker patients are being released into the community, often to the care of families who are not prepared or able to adequately care for them. One 65-year-old woman, a bilateral amputee with renal failure, with a colostomy, was sent home to an apartment with not running water, to the care of an unreliable 19-year-old grandchild. A 79-year-old woman hospitalized for a complete hip replacement, unable to walk or feed herself, was sent home alone where she was found several days later by a family member.

The Committee also learned that given the shorter length of stay and reduced staff in many hospitals, patients often are too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time needed to train the patient or family for home care.

Shortages in home health and nursing home care are aggravated by widespread illegal discrimination against Medicare and Medicaid eligible patients, witnesses told the Committee. Nursing homes prefer the more profitable private-pay patients and those for whom care is less costly.

HCFA has denied that demand for home health and skilled nursing care has significantly increased under PPS. Nevertheless, the Aging Committee's investigation confirmed with data from HCFA internal reports a nearly 40% increase in discharges to skilled-nursing and home health care since October 1983.

Options for community services narrow further when quality becomes part of the supply equation. HCFA cites more than 970 nursing homes as chronically substandard. Mrs. Mahla's mother was forced into such a home, where she died after 14 hours. For too many it is a choice of no bed, or a substandard one.

Access to home health and skilled nursing care is also restricted through the administration of the Medicare home health and SNF benefit. William Dombi, attorney from Legal Assistance for Medicare Patients in Connecticut, testified at the Committee's October, 1985 hearing that HCFA has "circumvented the law and suberted the intent of Congress . . . . through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare programs, the one that is on the books under 42 USC Section 1395 [and the one based upon the] directives of the Health Care Financing Administration." Other witnesses from the long-term care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines".

All of these factors contribute to reduced access to post-hospital care for Medicare patients. While some of these problems existed prior to the implementation of PPS, they clearly are magnified by the increased numbers of sicker patients being discharged from our Nation's hospitals. The Medicare Quality Protection Act addresses this problem in the following ways:

1. Require Discharge Plannings: Under current law, only hospitals that voluntarily choose to have a Department of Social Work are required to meet Federal rules for discharge planning (and these rules have been criticized as inadequate by health care professionals). HCFA plans to do away with even these lax rules. Existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS, with the result that Medicare patients often receive inadequate post-hospital care.

Take the case of Mrs. S, a 71-year-old woman who was sent home after a six-day hospitalization. She is legally blind, wears a pacemaker, is a diabetic, and has had a stroke and kidney failure. A home health nurse was not called by the discharge planner for four days. When the nurse arrived, she found the patient alone, with no food, taking the wrong medication dosage. This kind of tragedy should not happen.

The Medicare Quality Protection Act would make discharge planning a condition of participation for hospitals in the Medicare program, and for those hospitals deemed "certified" as a result of JCAH accreditation. Hospitals would also be required to have an effective discharge planning process. The bill spells out procedures to be followed when discharging a patient that were recommended by the American Association for Continuity of Care. Upon request of the patient, the attending physician, or someone acting on the patient's behalf, the hospital would be required to provide an initial discharge planning evaluation. Implementation of a final discharge plan would require approval of the attending physician.

2. Require HHS to study the need for Administratively Necessary Days: Many communities have a severe shortage of skilled nursing beds. Hospital patients in need of skilled nursing care in such a community are placed in a life threatening state of limbo. The hospital that keeps the patient ends up either absorbing the cost for the patient's sub-acute days of stay (Medicare covers only acute days of hospital care) or attempting to recover the loss from the patient. Alternatively, the hospital will send the patient home, with or without the necessary medical and social support services. Too often the latter scenario prevails. And as Medicare continues to ratchet down DRG payments to hospitals, making losses on sub-acute patients even less attractive, the number of elderly being discharged to inappropriate settings will rise.

Prior to PPS, Medicare paid for sub-acute care at a reduced rate until the patient could be transferred to a skilled nursing facility. These were referred to as payments for "administratively necessary days." Given the circumstances outlined above, it may be necessary to reinstate these payments. Under the Heinz-Stark bill, HHS is required to conduct a study to determine whether a separate payment should again be made to a hospital for "administratively necessary days," or days of care provided for skilled nursing patients who cannot be promptly discharged to skilled nursing care. The Secretary is required to report back to Congress not later than January 1, 1988.

3. Eliminate Unpredictable Retrospective Denials of Payment for Post-Hospital Care: Currently, there is a great deal of ambiguity and uncertainty about what Medicare covers for home health or skilled nursing care. This uncertainty is the result of unclear guidelines and vague definitions by HCFA and wide variations in decisions by the fiscal intermediaries (FIs) regarding payment for services needed.

Since the FI makes the coverage decision after services have begun, providers can be left without payment for care already delivered. If a potential patient's coverage under Medicare is in doubt, the facility may decide against providing that patient with services.

The Medicare waiver of liability was designed to give limited financial protection to health care providers who accept patients they have good reason to believe are eligible for coverage, but whose claims are denied after care has begun.

Obviously, elimination of this waiver might discourage health care providers from participating in the Medicare home health and skilled nursing program. But just last year, HCFA proposed that Congress do just that. Strong opposition by Members of Congress, providers, and beneficiaries resulted in Senate language in the Reconciliation Bill to extend the waivers. These provisions were agreed to by both Houses in conference on the Consolidated Omnibus Budget Reconciliation Act, and are now part of P.L. 99-272.

The Medicare Quality Protection Act would make permanent the waiver of liability for SNFs and HHAs. In addition, the waiver of liability would be extended to include denials made because it was determined that the patient failed to meet the homebound or intermittency requirements for home health coverage under Medicare. The bill also provides for an expedited retrospective review process, ensuring that the waiver will continue until the review determination is made by the fiscal intermediary. Finally, the bill enables providers to appeal denials of home health and SNF coverage on behalf of beneficiaries.

4. HHS to develop a Uniform Needs Assessment Instrument: Currently, there is no basis for judging how effectively health care services meet the needs of long term care patients or of ensuring that long term care patients are given the appropriate types or levels of care. A needs assessment tool can help providers to: (1) Objectively and consistently evaluate the health care needs of long term care patients and (2) match those needs with appropriate available long term care services. In this way, we can ensure that long term care patients have access to needed health care serv-

ices and that the long term care system can be wisely developed based on actual patient needs.

The Medicare Quality Protection Act requires HHS to develop, within one year of enactment, a uniform needs assessment instrument that evaluates: (1) the functional capacity of an individual; (2) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities; and (3) the social and familiar resources available to the individual to meet those requirements. This instrument shall be developed for the use of discharge planners, hospital and post-hospital providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care, home health, and other long-term care services.

III. IMPROVING PRO QUALITY ASSURANCE

HCFA has focused the PROs on a very narrow and incomplete set of quality issues; therefore HCFA's assessment of quality of care is grossly deficient. When the Aging Committee began its investigation in February, 1985, the quality assurance activities of the PROs were extremely limited. Hampered by HCFA's inconsistent and often unreasonable instructions, the PROs were only identifying the tip of the iceberg of quality problems developing under PPS. I am pleased to report that progress has been made in improving the ability of the PROs to monitor quality of care, and to exclude unfit providers and hospitals from delivering care to Medicare beneficiaries. But there are miles to go before the PROs are able to fully and effectively carry out their mandate as the watchdogs of quality under the Medicare program.

Under the new round of PRO contracts, now being negotiated with HCFA, the PROs' scope of review for premature discharges will be limited to those cases where the patient is readmitted to a hospital within fifteen days, and to those instances of possible substandard care that can be detected from using generic quality screens. This means that cases of readmission after fifteen days or to hospitals outside the PRO area, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital and lack of adequate care in the community will still not be reviewed by a PRO.

Thomas Dehn, M.D., President of the American Medical Peer Review Association, testified to the Aging Committee that HCFA primarily wants data from the PROs on utilization of stay—i.e., number of admissions, costs per admission etc.—and is less concerned with quality review. AMPRA's report, "PROs: The Future Agenda", dated September 1985 and prepared by their Task Force on PRO Implementation, states that "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality care concerns surfacing."

The PROs would thus like to broaden their quality review activities, and to review on a sample basis, quality problems beyond the hospital door. They can only do this, however, if they are given adequate funding and consistent guidelines from HCFA. In reviewing PRO performance, HCFA should give at least equal weight to quality assurance activities as is given to utilization review. In addition, HCFA must establish workable data transfers from the hospital to the PROs that will facilitate timely and efficient quality review.

The Aging Committee also heard from Medicare beneficiaries that PROs often are slow or completely fail to respond to their complaints about quality problems. Nor is there a mechanism to provide for beneficiary participation in decisions affecting PRO activity.

The Medicare Quality Protection Act takes a number of steps to address these problems:

1. Expand PRO Review of Quality of Care: Under the Heinz-Stark bill, PROs will be required to review selected samples of readmissions to hospitals within 30 days. They will also be required to review quality of care in selected home health, nursing, board and care homes, and outpatient hospital settings where they have identified potential quality problems. Finally, the bill requires hospitals to submit monthly data to enable PROs to perform reviews on a timely basis.

2. Allocate PRO Funds to Ensure Increased Quality Care Review: The Medicare Quality Protection Act requires that each PRO provide that a reasonable proportion

of its activities are involved with reviewing the quality of services provided in cases and settings for which potential problems of quality have been identified.

3. Improve PRO Accountability to Medicare Beneficiaries: The Heinz-Stark bill would require each PRO to appoint a consumer representative to its board. In addition, PROs would be required to investigate all written complaints about quality of care filed by a beneficiary (or a person acting on behalf of a beneficiary). HHS would develop appropriate procedures for investigating and responding to these complaints. These procedures would provide protection of the confidentiality of the complainant and provide that the PRO's report their findings to the complainant.

IV. IMPROVING DATA ON QUALITY OF CARE UNDER PPS

According to the GAO, HHS lacks any statistically valid basis to confirm or deny the effect of DRGs on the quality of health care older Americans need or receive upon discharge from the hospital. According to GAO testimony, HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, HHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

1. HHS to Develop a Long-term Quality Assurance and Review Strategy: The Heinz-Stark bill requires HHS to provide for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under Medicare. In developing this study, HHS shall consult with consumer groups, PROs, the Joint Commission on Accreditation of Hospitals, professional societies and private purchasers of health care with experience and expertise in monitoring the quality of care.

2. Extend HHS reporting requirements on quality in post-hospital settings: HHS is currently required to report on an annual basis on the impact of PPS. For these reports to be useful, they need to cover PPS effects on both hospital and post-hospital care. Under the Quality Assurance Act, HHS would be required to provide three annual impact reports providing: (1) An evaluation of quality assessment and assurance in the "continuum of care;" (2) an assessment of access problems of special beneficiary populations; and (3) data on Part A and Part B beneficiary appeals.

3. Sharing of Confidential Information Regarding Quality of Care: There is a woeful lack of information exchanged about problem health care facilities. Thus, hospital discharge planners are sometimes unaware that they are sending a patient to a substandard nursing home. Under the Medicare Quality Protection Act, instances of gross and flagrant patient neglect as well as patterns of poor quality care, could be shared with selected federally-funded quality assurance officials, provided that adequate assurance of confidentiality can be provided.

SENATOR GEORGE J. MITCHELL

Mr. Chairman, I appreciate your scheduling this hearing to examine the quality of care under Medicare's Prospective Payment System.

Since the implementation of the Prospective Payment System in 1983, we have witnessed significant changes in the way Medicare reimburses hospitals. PPS brought with it many incentives for hospitals to maintain the quality of care for elderly patients while working to reduce the costs of the program.

In an effort to assure that PPS did not compromise quality of care of patients, safeguards were built into the system. The most significant of these safeguards is the Peer Review process. Congress intended for the PRO to serve as the check on quality of care for elderly beneficiaries under PPS.

Does the PRO really serve as a check on the quality of care for the elderly under the Medicare program? There is much evidence that it has become primarily a cost containment measure, whose goal is not to protect the patient, but exclusively to reduce the cost of the Medicare program.

Congress must work to assure that the PRO does what we intended for it to do. If beneficiaries are in fact being discharged "quicker and sicker" should we not look to the PRO as malfunctioning? Before we act to reform existing law, we must work to assure that those programs designed to assure quality are being implemented as Congress intended.

As a Senator from a rural State with long, cold winters, I am particularly concerned about access to care and quality of care for those who live in rural areas. We must pay close attention to those in our states with the additional burden of distance and climate and consider reforms to PPS that would allow for those factors in making admission and discharge determinations. I regret that I must leave to attend another hearing but I look forward to reviewing the testimony to be presented at the hearing this morning.

As you know from our private discussion, Dr. Roper, I am deeply concerned about the PRO process nationally and in the State of Maine, where the PRO is from another state and has caused widespread dissatisfaction in our medical community. You, Dr., are from Alabama. How would the doctors in Alabama feel if they were reviewed by an organization from outside their own state?

I know we can work together to eliminate the shortcomings in the PPS system, keeping in mind the original purpose of the Medicare Program—to provide quality medical care to all of the nation's elderly.

BILL BRADLEY STATEMENT

I am pleased that the Committee is holding a hearing on quality of care to examine the ability of Medicare patients who are discharged from the hospital to secure appropriate post-hospital care and the impact of Medicare's DRG system on the quality of care in the hospital, including whether patients are being released before their need for hospital care has been met.

The DRG system provides an incentive for hospitals to reduce the length of a hospital stay to that period of time where acute care is absolutely required. This means that some people leave the hospital "sicker and quicker." And as Gramm-Rudman squeezes down on in-hospital reimbursement rates, it is natural to assume that hospitals will be under increasing pressure to reduce hospital costs, thereby discharging patients earlier and earlier.

Recently I introduced the Medicare Home Care Improvement Act, cosponsored by Senators Heinz and Glenn, which includes the following provisions:

First, the bill mandates discharge planning. Currently, many elderly beneficiaries are being discharged from hospitals without adequate planning for their home care needs. My bill requires all hospitals to develop a discharge plan for their patients that evaluates the patients' likely need for appropriate home care services and the availability of those services. In addition, all health care facilities would be required to develop a discharge plan for all in-hospital patients as well as patients scheduled for ambulatory, or out-patient, surgery.

Second, the bill stops HCFA from circumventing the regulatory process. Over the past few months, HCFA has unilaterally promulgated major policy changes through written and verbal directives and manuals, rather than through the regulatory process. This gives the public little or no opportunity to comment on changes in policy. My legislation ends that practice and requires HCFA to comply with the Federal Administrative Procedures Act. This would ensure that policy changes are only instituted through the normal regulatory process, which will permit a thorough review of changes in policy by Congress and the general public.

Third, the bill stops HCFA from arbitrarily restricting reimbursement for various home care services. HCFA recently established a new policy that limits reimbursement levels for each type of home care service, including skilled nursing services, physical therapy and social work services. These policies severely restrict the capacity of home care agencies to provide a full range of services to meet the need for services in their particular communities. My bill prohibits HCFA from establishing separate cost limits and allows home care agencies to continue to combine costs in order to better meet the needs in their community. In addition, the bill requires HCFA to take into account all legitmate costs when it establishes reimbursement for home care services.

This hearing represents a good opportunity for us to assess whether the elderly are receiving quality services—both in the hospital and after their discharge to their homes. It is my hope and anticipation that this Committee will adopt legislation to ensure that quality be high.

QUALITY AND ACCESS TO HEALTH CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

BACKGROUND PAPER

PREPARED BY THE STAFF FOR USE OF
THE MEMBERS OF THE COMMITTEE ON FINANCE

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Appendix -- A message from Medicare

I. BACKGROUND

As authorized by P.L. 98-21, the Social Security Amendments of 1983, Medicare implemented a prospective payment system (PPS) for inpatient hospital services on October 1, 1983. The intent of the new PPS system was to constrain the growth of inpatient hospital costs. However, the law also requires that the prospective payment rates reflect costs "necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality."

The prospective payment system radically changes the method by which Medicare pays hospitals. It also reverses the economic incentives to hospitals. Under the previous cost-based system, Medicare retrospectively paid hospitals for the costs they incurred in providing services to Medicare patients. Under PPS, Medicare pays hospitals a fixed rate determined in advance for each Medicare patient according to the the cost of resources used by an average Medicare patient with the same diagnosis. Separate rates are calculated for urban or rural hospital locations, and the rates are adjusted for several hospital characteristics such as the area wage rate and the hospital's teaching status. Although the payment rates are based on average utilization and cost data, the payment system does not place any limits on the amount of care the Medicare beneficiary receives from the hospital. As under the old payment system, Medicare beneficiaries are entitled to medically necessary hospital services. Regulations require hospitals to discharge Medicare patients only when they are medically stable.

To encourage hospital efficiency, PPS allows the hospital to keep the difference between the Medicare payment rate and actual patient costs as a profit. However, the hospital must absorb the loss if its costs are higher than the payment rate. PPS assumes that the financial risk to the hospital is minimal for four reasons. First, the PPS system assumes that under the old payment system a certain amount of hospital care was unnecessary and/or inefficient. Since PPS rates were initially based on pre-PPS behavior which encouraged hospitals to spend more to be paid more, it is assumed that hospitals could benefit by becoming more efficient. Second, the PPS system assumes that on average a hospital is able to recover losses on any expensive cases with savings on cases that use fewer resources. Third, PPS recognizes that some patients may have complications that require either longer or more expensive treatment than the average. Thus, the system includes an exceptions policy to permit extra payment for these cases, known as "outliers". Finally, PPS includes a transition period to permit hospitals to adjust their practice patterns to payment rates which will ultimately be based on national averages.

PPS introduces many incentives for hospitals to increase quality of care. It provides incentives to reduce length of stay and unnecessary services, thus reducing patient exposure to the risk of complications, hospital accidents, and infections. It offers incentives for hospitals to specialize, thus reducing the risk of adverse outcomes. Physicians are required by hospitals to more carefully assess whether tests or procedures are necessary for patient recovery and to manage a patient's treatment throughout the hospital stay. Placement of patients in an appropriate level of care is encouraged.

While PPS provides a positive incentive for a hospital to be more cost-conscious and to increase quality, it also introduces a potential incentive for hospitals to look for ways to increase revenues or reduce the costs per case. For example, a hospital could increase its revenue by: admitting patients who do not require hospital care; discharging patients early; failing to provide medically necessary services; discharging and then readmitting patients for treatment of secondary conditions; and transferring or refusing to admit patients who have complications. Further, a hospital could shift the patient, or certain services required by the patient, to outside settings such as the hospital outpatient department, home health agency, or skilled nursing facility. In these latter three circumstances, the outpatient care is not deducted from the hospital's prospective payment rate, but it is separately billed to Medicare.

Congress recognized that the incentive for a hospital to increase its revenues or reduce its costs had the potential to compromise the quality of care provided to Medicare patients. Thus, three safeguards were built into the system. First, physicians are expected to assure that adequate and appropriate care is provided to their patients. Second, the Secretary of the Deparment of Health and Human Services (HHS) was directed to evaluate the impact of the new payment system and to submit a number of reports to Congress. Finally, each PPS hospital is required to have a contract with a Peer Review Organization (PRO) to provide an independent assessment of payment and quality under PPS. If the PRO finds that inappropriate or substandard care is delivered, the Medicare payment could be denied or the hospital could lose its Medicare approval.

There is substantial evidence that hospitals had a strong and early response to the cost efficiency incentives in the new payment system. During the first year, length of stay for Medicare beneficiaries fell by 9 percent. In early 1985, the decline in average length of stay continued, but recent data reported by the American Hospital Association indicate that the downward trend has leveled off with a small increase reported during the fourth quarter. (1) Medicare admissions declined 4 percent, the first decline since the program was initiated. Hospitals reduced expenses through laying off staff, eliminating beds, and negotiating lower prices with suppliers. Unnecessary use of expensive inpatient services also was curbed. For example, a study by the General Accounting Office (GAO) found that use of intensive care units by Medicare patients was lower in 1984. GAO concluded that this response was attributable to the prospective payment system's incentives. (2) The Commission on Professional and Hospital Activities found that the use of cardiac care units also declined during the first year of PPS. (3) PPS also encouraged hospitals to limit the inpatient stay to those services necessary to stabilize the patient's condition. Patients who need recuperative care or care requiring less intensive medical supervision are now discharged to skilled nursing facilities (SNFs) or home settings. Extra hospital days for the convenience of the patient or their family, which may have been paid for under the former cost-based payment system, are no longer considered part of the inpatient hospital stay. Further, many hospitals no longer permit the patient to remain in the hospital until a suitable skilled nursing facility bed is available. Under the cost-based payment system, these "administratively necessary days" were paid by Medicare; under PPS these days are included in the payment rates. Many hospitals acquired ambulatory care facilities and home health agencies to accommodate this new demand for post-discharge services.

The Health Care Financing Administration (HCFA) concludes that the role of the hospital in the health delivery system appears to be changing as hospitals are used less and are in the position of competing for patients with other acute settings such as non-hospital ambulatory surgical centers. Increasingly, hospitals no longer are viewed as the primary site of treatment but rather are viewed as part of a continuum of care. (4)

These hospital behavioral changes have resulted in changes in the patterns of care for Medicare beneficiaries by shortening their stays in the hospital and shifting care to nursing homes and home settings. However, there is little evidence to assess how these delivery system changes have impacted the quality of patient care. Some of the questions on the effects of PPS on Medicare patients that currently are being asked are whether patients are being admitted or readmitted to a hospital appropriately; whether access to necessary medical care has changed; whether tests and procedures are adequate; whether discharges are premature; whether appropriate post-hospital services are available; and whether PPS effects are distributed uniformly across payment categories, patients and geographic areas.

This paper reviews the evidence to date.

II. WHAT IS QUALITY CARE?

There is no universally accepted definition of, nor is there a standard way to measure, whether health care services are of high or low quality. There are various ways to consider quality. Patients generally assess quality in terms of whether care is accessible, affordable, or meets their expectations. Physicians generally use a set of practice patterns against which quality is measured on a local basis. Researchers have noted that these practice patterns vary significantly across the country. For example, studies by Dr. John Wennberg of demographically similar areas show significant variation in utilization of elective procedures. (5) Utilization by Medicare patients of medical and surgical services and costs of treatment also varies across the country. Before PPS, average Medicare admissions per 1,000 enrollees ranged from 349 to 477, and average Medicare length of stay ranged from 8.1 to 12.7 days. The cost of treatment for heart failure ranged from $1,500 at one hospital to $9,000 at another hospital. The overall implications of these utilization and cost differences on quality of care have never been clearly understood; however, studies have not revealed any differences in outcome measures such as mortality or health status of patients. Further, it is not clear whether higher or lower rates imply inappropriate use. (6)

Health professionals have defined measures of quality in three categories -- "structure", "process", and "outcome". (7) "Structure" refers to such factors as adequacy of physical facilities and staff qualifications. Criteria to measure these factors are set by professional associations or public entities through regulation. Fire safety codes are an example of state regulations. "Process" reflects activities related to patient treatment, such as medical procedures and nursing care. "Process" is usually measured through comparisons to professional norms of practice, for example, the practice of sending a patient to the hospital for the treatment of a specific condition or the average length of stay for a certain condition. Utilizaton review is a common approach for evaluating patient care based on "process" measures. "Outcome" refers to the change in a patient's health status. A wide array of scales and indices have been developed to measure health outcomes, such as, death rates or levels of patient functioning. While patient outcomes are the most important aspect of quality of health care, it is easier and less expensive to measure the "structure" and "process" of hospital care. To date, a mechanism has not been developed which links "structural" and "process" measures to "outcome" measures. Further, review of these three measures of quality usually is focused on the individual provider, such as the hospital, and may not consider the total episode of patient care which may involve hospital care, physician services, and post-hospital services such as home health care. Thus, the state of the art in quality review is often a "snapshot" of care at a point in time.

The original Medicare legislation included two types of review to assess the quality of hospital services, "structural" review to assess such factors as the hospital's facility, and utilization review (a "process"- oriented review) to assure that Medicare payments were made only for "necessary" services.

"Structural" review is accomplished through Medicare's requirements that hospitals be accredited by the Joint Commission on Accreditation of Hospitals (or other similar process) and that review assure that hospitals meet Medicare's "condition of participation" requirements, for example that the hospital meet State licensing requirements. Utilization review is accomplished by peer review of the appropriateness of hospital and physician decisions according to local community standards.

In 1972, Congress created Professional Standard Review Organizations (PSROs), groups of private physicians established to provide an independent assessment of Medicare services. PSROs were intended to review:

a) whether Medicare services were medically necessary,

(b) whether admissions and lengths of stay were appropriate,

(c) whether quality met professionally recognized standards of care, and

(d) whether services should be delivered in an inpatient or less expensive outpatient setting.

To correct the difficulty in measuring PSRO's performance and strengthen review of the costs of Medicare services, in 1982 Congress replaced the existing PSROs with a new program of independent peer review known as Peer Review Organizations (PROs). The new PRO legislation emphasized greater accountability by requiring PROs to have performance-based contracts with specific, measurable objectives. With the passage of the prospective payment system in 1983, the role of the PROs was expanded to include review of changed hospital behavior under PPS including a new emphasis on review of underservice. PROs were required to have agreements with PPS hospitals to review appropriateness of care by November, 1984, almost a year after the new PPS system was begun. Between October 1983 and the effective date of the new PRO agreements, fiscal intermediaries and PSROs were responsible for reviewing quality of care issues.

The specific tasks performed by PROs are defined in contracts. The first contract covered the 1984-6 period. These contracts emphasized detection of inappropriate utilization and payments under the new PPS system. For example, contract goals included reducing unnecessary admissions, assuring that payment rates matched the diagnostic and procedural information contained in patient records, and reviewing patients transferred or readmitted within 7 days of discharge to determine whether readmission was for the same condition as the first hospital visit. In addition, each PRO contact included a minimum of 5 locally determined quality objectives. The quality goals included: reduce unnecessary readmissions because of substandard care during the prior admission; assure provision of medical services that if not performed have a signficant potential for causing serious patient complications; reduce unnecessary surgery or other invasive procedures; reduce the risk of mortality; and reduce avoidable postoperative or other complications. PROs also were required to develop and analyze hospital, physician, and Medicare patient data to identify instances and patterns of poor quality.

When a PRO identifies a problem with a hospital or physician, it can take several courses of action. It may attempt to solve the issue through:

(a) education and consultation,

(b) intensified review,

(c) recommendations for payment denial, or

(d) if there is a substantial violation in a substantial number of cases, recommending that

HCFA impose a sanction such as terminating a hospital or physician from the program.

The recently enacted reconciliation legislation, P.L. 99-272, included a provision that clarified legislative authority to permit PROs to deny payment for individual cases that they determine received treatment that was of substandard quality. Before this legislation, PROs could deny payment only where they determined that the care was not reasonable and necessary or it was not provided in the appropriate setting.

During the first contract period, PROs were funded to review care only in the inpatient setting, not the outpatient setting.

III. QUALITY OF CARE DURING THE FIRST TWO YEARS OF PPS

Prior to PPS, quality of care provided to Medicare beneficiaries was generally considered to be good. If there was a question about the need for an extra day of care or an extra test, it was generally provided because Medicare would pay for it. However, before PPS, there was little systematic evaluation of quality of care provided during the hospital stay and no evaluation of access to appropriate post-hospital care. Most of the quality reviews focused on whether services were necessary and whether individual facilities met specified requirements. In addition, physicians and providers maintained considerable discretion in determining locally what was appropriate, necessary, and met professional standards.

A number of studies have been undertaken to assess the impact of PPS on the quality of care provided to Medicare beneficiaries. Some of the studies suggest that there were problems with the transition to the new PPS system, or identify anecdotal cases where the changed patterns of hospital care had a negative impact on patient health or access to necessary and/or appropriate services. Other studies find that the new PPS system has not resulted in a decline in the health status of Medicare beneficiaries and suggest that on the whole, care may be of a higher quality since patients are being served at a more appropriate level. However, most of the studies acknowledge that hospital response to the PPS system was faster than anticipated and that data to measure the impact either have not been available or have not been collected in a way to permit an assessment of the quality and access effects after two years of PPS operation. The quality review included in the first PRO contracts generally is considered to be insufficient to assess the effects of PPS either in the inpatient hospital setting, or after patient discharge.

A summary of the findings of the major studies follows. It should be noted that studies which indicate that there are no serious quality problems under PPS caution that longer term studies are necessary to determine whether quality may decline in the future, particularly if cost containment pressures increase.

A. PRO Review

During the period October 1983, to May 1985, PROs reviewed approximately 2.1 million hospital admissions. The PROs targeted 345,700 cases for review because there were readmissions within seven days of a hospital discharge or the patient was transferred to another hospital or PPS-exempt unit (e.g. a rehabilitation unit). Of those, 4,724 cases (1.4 percent of the PRO targeted cases) were reported to HCFA for possible corrective action. (8) The PRO review did not include cases where the discharge, although possibly premature, did not result in a readmission; the readmission occurred after 7 days; or the readmission was at another hospital.

As of May 1985, PROs have referred 26 cases to the Inspector General (I.G.) for possible sanctions. Ten of these cases have been reviewed by the I.G. Nine sanctions were recommended including exclusion of one hospital for 3 years; exclusion of six physicians; and assessment of money penalties against two physicians. One hospital case was rejected. All sanction actions have been appealed.

B. General Accounting Office

In July 1984, GAO conducted an audit in six communities and found that some patients were being discharged from hospitals after shorter lengths of stay and in a poorer state of health than they were prior to the new payment system. (9) Home health representatives at several of the review sites reported that Medicare patients required more visits per week, more visits per case, and more need for specialized services (such as I.V. therapy and catheters) than before PPS. Interviews with nursing home and home health providers expressed concern that Medicare was not making appropriate adjustments to coverage rules or reimbursement amounts to respond to the perceived changes in the needs of patients. GAO concluded that the potential for the problems found in the six study communities to become serious could vary considerably because of differences in regional and local conditions. The GAO recommended that HHS conduct studies to assess problems in access to and quality of post-hospital care services supported by Medicare.

C. Physician Surveys

In December 1985, the American Medical Association reported the results of a survey conducted as part of their DRG Monitoring Project. (10) Sixty-six percent of the 389 responding physicians said that quality of patient care had deteriorated as a result of PPS. Their reasons included pressure from hospital administrators to discharge patients for a primary condition and readmit them for a second condition; pressure to discharge patients prematurely (that is, while they still need acute care services available in a hospital); and pressure to reduce the number of tests and procedures ordered.

In September, 1985 the American Society of Internal Medicine reported the findings of a survey of 246 physician members. (11) Respondents reported pressure from hospital administrators to discharge patients prematurely, in particular, patients with health conditions requiring high resource use such as Alzheimer's patients and pressure to discharge patients without concern for appropriate follow-up care. The study recommended that adjustments be made in the prospective payment rates to better reflect variations in the costs of caring for certain patients, such as stroke or leukemia cases.

A more comprehensive survey of 4,000 physicians conducted by Health Economics Research, Inc., and the National Opinion Research Center reported similar impressions that quality had deteriorated as a result of PPS. (12)

None of these surveys documented how shorter lengths of stay or fewer procedures affected patient health outcomes.

D. Senate Aging Committee

Investigations conducted in 1985 for the Senate Aging Committee found a small number of cases where the new cost-cutting behavior of hospitals and physicians had a negative impact on patient health. The nine case studies presented at Congressional hearings were examples of patients who were prematurely discharged when they were severely ill, resulting in readmission to the hospital, delayed recovery, and, in one case, death. These cases also suggested that hospitals and physicians failed to assure that an adequate hospital discharge plan was developed that would include proper instructions for follow-up care. Information also was provided that Medicare beneficiaries often had extra out-of-pocket costs due to reduced hospital care and that post-hospital services were not always available. The Aging Committee found that beneficiaries were misinformed because they believed that the PPS legislation had established a limit on the number of days of hospital care that were allowed and patients received no information on how to appeal the hospital's decision to discharge. The Senate Aging Committee investigation determined that all of these quality issues were outside the purview of the PRO review as defined in the first contract requirements. (13)

E. HHS Inspector General

In March, 1986 the Inspector General (IG) of HHS reported findings from a more comprehensive review of the two most common problems identified earlier -- premature discharges and inappropriate transfers. (14) The IG study reviewed 3,549 cases which represented all of the problem cases where records could be found reported to HCFA by PROs or other sources during the period October 1983, to May 1985. Of the 3,549 cases, discharge was premature in 2,907 cases, transfers were inappropriate in 491 cases, and other problems existed in 151 cases. Sixty percent, or 2,146 of the reviewed cases, actually suggested poor quality while the remaining forty percent were prematurely discharged or inappropriately transferred for reasons that did not involve poor quality, such as, completion of a diagnostic workup prior to surgery. The IG found that quality problems ranged from very minor to gross and flagrant, with most of the problems occurring in cases with premature discharges (2,050 cases). Quality problems included cases that were not appropriately treated (e.g. infections, failure to perform routine tests); cases where the patient was treated appropriately but released too early in the course of treatment; cases that were discharged in a medically-unstable condition; and cases where the patient was unable to manage post-acute care at home and had to be readmitted to the hospital.

Of the 2,146 cases where quality problems were found, PROs referred 927 cases to HCFA for corrective action and the remaining cases were handled by the PRO through education or intensified review. The actual penalties applied to the abuses ranged from none to fiscal penalties. The IG report concluded that many PROs have not effectively used the authorities or processes available to address poor quality of care associated with premature discharges and inappropriate transfers. The study also found problems with PRO contract requirements, with PRO data collection efforts, and with inadequate HCFA instructions. The IG recommended that HCFA and PROs aggressively address these problems.

F. RAND

A study conducted by Rand identified a number of weaknesses in the scope of work for PRO review of quality of care during the first two years of PPS. (15) The focus of PROs on inpatient care meant that problems with care that occurred after discharge were not reviewed. The review of care in the hospital itself emphasized only major problems such as death or serious complications and focused on utilization and payment review rather than quality concerns such as patient outcomes. PRO review did not consider the appropriateness of the discharge plan, such as whether appropriate supportive services were available, and did not include any provisions for beneficiary or provider education. The reporting burden hampered the ability of PROs to consider quality problems.

Rand recommended that the quality objectives in the 1984-6 PRO contracts be broadened to include generic screens (standaard measures against which quality problems can be identified such as evidence of nosocomial infection) and that quality review be given greater weight. Rand also recommended that quality review be extended beyond the hospital setting to focus on the entire episode of care; and that more flexibility be given to PROs to address quality problems in local areas.

G. The Prospective Payment Assessment Commission

ProPAC is an independent commission established by Congress to analyze and recommend changes in the prospective payment system. ProPAC believes that the current PPS payment levels are adequate for the provision of quality inpatient care, but will continue to monitor access and quality because the incentives in PPS may lead hospitals in the future to compromise quality. The second annual ProPAC report concluded that negative perceptions of the quality of care under PPS are widely held and that some of these perceptions do not reflect the actual quality of care received, but rather the misinformation communicated to the beneficiary. (16) The Commission recommended that better information be provided to beneficiaries, hospitals and physicians, in particular clarification that PPS does not require a specific length of stay for each payment catagory. ProPAC also identified that the premature discharge problem may not be inefficient hospital service but rather inadequate clinical management of the case.

ProPAC recommended that the PRO review be extended to the overall episode of care including SNF and home health care and outpatient surgery. Although ProPAC believes that the current PPS system is the most appropriate of the available measures of hospital case mix, there is recognition that resource use varies considerably within some payment rates. The second annual report includes several recommendations to improve payment rates. ProPAC is continuing studies to identify ways to improve payment rate equity where there are problems, and to assess the appropriateness of outlier policies. ProPAC studies will consider whether vulnerable groups, such as the frail elderly, have special problems. In addition, ProPAC will assess whether PPS has increased out-of-pocket costs for beneficiaries resulting in reduced access to Medicare covered services.

H. Commission on Professional and Hospital Activities

CPHA found that quality of care did not decline during 1984, the first year of PPS. The study, based on data from 729 hospitals, found that physician visit rates remained constant, in-hospital deaths and readmission rates were consistent with previous trends, and there was no evidence of "dumping" undesirable patients into SNFs or other short-term hospitals. This study concluded that hospital behavior changes probably represent improvements in both clinical and management efficiency by eliminating some of the slack in the system. However, this study expressed the need for further studies, particularly studies on the impact of shifting patients to settings outside the hospital (including the home setting where the family assumes more responsibility for post-hospital care), changes in clinical practice patterns within selected diagnostic categories, and post-discharge health outcomes. CPHA attributes the apparent increase in the severity of illness of patients upon discharge to improved coding and the fact that hospitals are classifying patients at a higher level to assure the highest payment rate. (17)

I. Health Care Financing Administration

In November, 1985, HCFA reported the results of a study of access and utilization indicators that found that the reduced number of hospital discharges under PPS did not disproportionately represent high risk groups or groups with potential access problems. HCFA also found little change in the relative utilization of, or access to, hospital services by Medicare beneficiaries across age, sex or race categories. The study also found that rehospitalization rates within 30 days of discharge did not increase during the first year of PPS. HCFA concluded that quality of care problems are not systemic under PPS since PRO review found less than one percent of all Medicare patients had potential quality problems. (18)

J. Health Economics Research, Inc.

Health Economics Research, Inc., looked at beneficiary perceptions of the impact of PPS. This study found few incidents of beneficiary reported problems with the new payment system and widespread misinformation about PPS on the part of patients, physicians, and hospitals. (19) This study concluded that the frequency of complaints about premature discharge is a result of a clash between the expections of the elderly about the extent of their Medicare benefits and hospitals' implementation of PPS. The primary beneficiary complaint was that the hospitals sent them home before they felt ready, despite the fact that the physician had made the decision to discharge. The study found that home care services were available in most cases, but that transfer of some medically unstable patients to SNFs presented health risks. The report also documented that most beneficiaries have increased financial burdens when transferred to post-hospital care providers that are not covered by supplemental health insurance policies.

K. Office of Technology Assessment

The Office of Technology Assessment (OTA) concluded that while there is evidence that patients are being discharged from the hospital in a sicker condition than before PPS, there is no clear evidence to indicate whether the ultimate impact on the quality of patient care is good or bad. OTA recommended that a 5-year evaluation strategy be undertaken to assess the evolving effects of PPS, both positive and negative, and that studies be funded to develop more appropriate methods and standards to assess PPS effects on quality and access. (20)

IV. CORRECTIVE ACTION

In response to Congressional and other inquiries about premature discharge, the Health Care Financing Administration undertook several reforms to strengthen quality of care review under PPS.

In August 1985, HCFA issued new rules to clarify that all premature discharges made before the patient is medically stable are considered substandard quality. PROs were directed to deny payment when the result of a premature discharge was readmission to the same hospital or transfer to a PPS-exempt hospital and to take corrective action in other cases by preparing a sanction report, intensifying review or referring the case to the Inspector General.

In February 1986, HCFA developed a one-page information sheet (see appendix) to inform beneficiaries of their rights and liabilities under PPS and the method to be used by patients to appeal the decision of the hospital to discharge them from inpatient care. HCFA instructed fiscal intermediaries and PROs to instruct hospitals to distribute these notices to Medicare patients.

HCFA strengthened the quality review requirements in the second PRO contracts which begin July, 1986. First, the criteria for review of discharged cases which are readmitted to the same hospital was extended from 7 days to 15 days. A requirement was added for PROs to review a sample of discharges to assess whether there is evidence of premature discharge or transfer. Certain hospitals were identified for special review because of unexplained statistical outliers in the PRO data on high mortality rates or utilization patterns. All cases are to be reviewed against 6 generic quality screens to identify problem areas. These include adequacy of discharge planning; medical stability of the patient at discharge; deaths; nosocomial infection; unscheduled return to surgery; and trauma suffered in the hospital. Short hospital stays are targeted for special review. A PRO-sponsored community outreach program was added to help beneficiaries understand the appeals process and the role of the PRO. In addition, an independent contractor was hired to evaluate the performance of the PRO contracts, including the assessment of quality of care review. These changes in the PRO review effort were designed to increase detection of premature discharges; to improve review of care in the hospital, particularly the detection of situations where underservice may impact the quality of patient care; and to improve the patient's understanding regarding their rights and appeals under the new system. No changes were made in the review of post-hospital care other than to assess whether discharge planning is appropriate. The appeals process was not modified.

In addition to the above actions, research has been initiated by HCFA, the Prospective Payment Assessment Commission, and other organizations to review ways to improve monitoring of quality of care under PPS. The results of these studies will be used to assist PROs to monitor quality of care in the future. Several major studies are highlighted below. Some of the early results of these studies are included earlier in paper. Many of the final results will not be available until 1988 because data first must be collected before analysis can be undertaken.

A study by the Rand Corporation will specifically measure the impact of PPS on the quality of care to Medicare patients. It will review patients in 6 categories in 4-6 states before and after PPS. The analysis will consider whether the medical treatment choices were proper and if they were different when the cost factor was introduced. Rand also will conduct a study on how to develop measures that will detect quality of care problems in an individual hospital.

HCFA and its contractors also are conducting studies that use existing data to examine outcomes of hospital care on the health status of Medicare patients, for example, to detect changes in patient death rates and to monitor changes in hospital utilzation patterns such as average lengths of stay.

The Oregon Health Systems Agency is reviewing patients in 5 diagnostic categories to determine if patients were more dependent (i.e., needed more assistance in caring for themselves) at the time of discharge from a PPS hospital than they were when hospitals were paid on cost reimbursement.

A study by the American Medical Association and Johns Hopkins University will assess the impact of PPS on changes in hospitalization patterns.

V. POST-HOSPITAL QUALITY OF CARE

Early studies have raised serious questions about the effect of PPS on access to quality care after hospital discharge. Because PPS was developed to reform Medicare's hospital payment system, the PRO review effort and the data PROs were required to collect have focused on changes within the hospital setting. Thus, little is known about the availability, appropriateness, or affordability of post-hospital care.

Anecdotal information has disclosed 2 types of post-hospital patient. The first is the patient who leaves the hospital and secures adequate post-hospital services that are covered by existing Medicare payment policies. Post-hospital services covered by Medicare include up to 100 days in a SNF, sub-acute care in a rural hospital "swing-bed" (when the inpatient hospital bed has been approved by Medicare for extended care), and an unlimited number of home health visits. Medicare policies limit payment for these post-acute care services. For example, a Medicare patient must pay a large coinsurance ($61.50 per day in 1986) after 20 days in a SNF. Medicare does not pay for any care in lower level nursing homes (not "skilled level"), such as intermediate care facilities. To qualify for the home health benefit, the Medicare beneficiary must be homebound and require intermittent, skilled services. These restrictions are intended to assure the "acute" nature of the post-hospital benefit.

The other type of patient allegedly falls through the cracks into what some observers call a "no-care zone". (21) These patients may either need more care than current Medicare payment levels and/or coverage criteria permit, or lack access to post-hospital care because of the non-availability of nursing home beds or home health services in their communities. It is not clear how many patients fall into this "no-care" zone. In several states, post-acute care after discharge from a PPS hospital is being referred to as a new category of care, sometimes called "transitional" care. Often this care is provided by a skilled nursing facility, but in some states, because of a surplus of empty hospital beds and/or a shortage of nursing home beds, this "transitional" care is provided by the hospital with costs directly billed to the patient. These costs are not usually covered by existing supplemental health insurance policies. A study by Interstudy in one state concludes that to date this practice is small, representing only 2 percent of Medicare discharges. (22)

HCFA reports that there is no systematic evidence that access to needed post-hospital care has been

HCFA reports that there is no systematic evidence that access to needed post-hospital care has been hampered by PPS. Data on SNF admissions show a one percent increase in 1984 over 1983. Use of home health visits has continued to increase, at higher growth rates than before PPS. (23) This growth in post-hospital care was expected as hospitals discharged patients to other settings.

The National Association for Home Care (NAHC) has expressed concern that despite the growth in the number of home health benefits paid by Medicare, many beneficiaries are unable to secure necessary post-hospital care because administrative restrictions have tightened coverage requirements. In particular, NAHC has cited stricter definition of the homebound and intermittent care requirements as incompatible with the needs of patients who are released from hospitals at an earlier stage in their recovery. (24)

In November 1985, the GAO reported that existing studies of PPS effects do not adequately address the problem of measuring changes in a patient's condition at hospital discharge nor the use of, expenditures for, access to, and quality of post-hospital care. (25) Since GAO produced its report, a number of new studies have been initiated. ProPAC is assessing hospital discharge practices and how well inpatient services are linked to post-discharge care. ProPAC will also assess whether increased out-of-pocket costs reduce beneficiary access to services. Abt Associates is undertaking a study of Medicare covered hospital, SNF, and home health services to determine whether patterns of sub-acute care and beneficiary out-of-pocket costs have changed since PPS was implemented. An HHS study conducted by System Sciences will look at the status of a national sample of Medicare patients at hospital discharge including functional status, dependency and severity of illness. It also will consider the special problems of elderly persons who live alone. In addition, the Institute for Health and Aging at the University of California, San Francisco will assess whether Medicare patients who are discharged from a PPS hospital have more acute and complex medical problems than in the past and assess how the community support system has changed in response to reduced hospital admissions and shorter lengths of stay.

VI. ISSUES

The prospective payment system has been successful in accomplishing its goal of controlling hospital costs. Although some Medicare beneficiaries may wish to stay in the hospital one or two days longer than the physician orders, evidence to date indicates that most Medicare beneficiaries continue to receive high quality care both in the hospital, and from a home health agency or skilled nursing facility after hospital discharge. According to ProPAC, the PPS rates are sufficient to insure quality inpatient care and, given information currently available, appropriate payment adjustments are made for hospital and patient differences. In addition, PROs are now in place to review hospital care and their contracts now direct them to detect substandard care.

However, the new payment system has stimulated a reconfiguration of the health delivery system that has shortened hospital stays and increased care in non-hospital settings. The extent to which quality of care has changed as a result of these new patterns of care is not clear. While the reports mentioned in this paper cite anecdotal evidence of cases where there may be quality or access problems, there is no evidence to suggest that quality or access problems are widespread or that the prospective payment system needs radical reform at the current time. The recent reforms initiated by the Health Care Financing Administration should alleviate some of the transitional problems that emerged during the implementation of the new payment system. In particular, changes have been made to correct Medicare beneficiary misinformation about Medicare payment limits and the process for appeals; and to improve the detection of premature discharges and the underprovision of care in the hospital. Whether these reforms are sufficient remains to be seen.

Several other questions have not been addressed by the evidence to date. These include whether beneficiaries are being admitted to and discharged from the hospital appropriately; whether access to appropriate post-hospital services is assured; and whether and how PPS effects are distributed across DRGs, patients and regions. Research studies have been initiated to address these questions, however, findings will not be available for another two years. It is not clear whether these studies will answer the full range of quality-related questions or whether there will be unanticipated problems with the measurement of quality effects due to the lack of pre-PPS baseline, the lack of agreement on what constitutes quality care, or technical difficulties in obtaining or intrepreting the data.

Once the quality problem is defined, potential reforms need to be considered. Reforms can be made in the way that Medicare pays for hospital or post-hospital care; the way that health delivery is structured; or the way that quality is measured. In any case, the ability to make reforms will be constrained by the availability of funds.

If a reform of the payment system is considered, several options are possible. One approach would be to modify the current prospective payment system for hospitals. If the problem is defined as insufficient funds for certain cases in certain categories, adjustments could be made in the definition of outlier payments, the method of payment for administratively necessary days, or the method of adjusting payments for severity of illness. If one determines that payment is insufficient for post-hospital care, one could modify the method or the definition Medicare currently uses for nursing services or home health care. If the problem is defined as the need for a continuum of care, it may be more practical to expand the prospective payment rate to include payment for the entire episode of care, that is, for all care necessary to treat the condition for which the patient was hospitalized, whether the treatment is provided in the hospital, home, or nursing home.

If a reform of the health delivery system is considered, several options are possible. One approach would be to add new procedures to the current system to correct inadequacies. For example, if the problem is defined as improper patient referral to post-hospital care services, a correction could be made to require all hospitals to conduct discharge planning. A uniform discharge planning format, with procedures to assist the discharge planner match the patient to the correct level of care, could be developed. Criteria to help planners identify vulnerable groups, such as the frail elderly who live alone, would also facilitate the resolution of access problems. If the problem is defined as the need to assist the beneficiary through the entire episode of care, one could develop a case management system where the physician or another person or entity manages the patient through the system. Given the large volume of Medicare admissions, this approach may be impractical.

There are several options to reform the system to review quality of care. One approach would be to monitor the effectiveness of the expanded PRO quality review system. Another approach would be to extend the PRO system to the entire episode of care, including home and SNF care. A problem might be encountered in conducting quality review beyond the hospital setting because review of the quality of outpatient care is even less sophisticated than measurement of inpatient care. In addition, the determination of appropriateness of specific levels of care is in its infancy. Another approach would be to focus efforts on improving the definition of quality of care and the tools to measure the presence or absence of quality services.

VII. LEGISLATIVE PROPOSALS

The following bills have been introduced in the Senate to improve quality of Medicare services.

S. 778

On March 28, 1985, Senator Heinz introduced S. 778, the "Home Care Protection Act of 1985", which provides that nursing care and home health aid services may be provided on a daily basis as a Medicare covered home health service with monthly physician certification and thereafter under exceptional certifications. This bill is cosponsored by Senators Bradley, Bentsen, Pryor and others.

S. 1620 (H.R. 3253)

Senator Durenberger introduced S. 1620 on September 10, 1985, a bill to establish a National Council on Access to Health Care. Among its responsibilities, the Council would undertake advisability studies on:

a) the development of a national health care policy to address the issues of access and quality;

b) the differences in the quality and availability of health care services for various economic and geographic segments of the population; and

c) current procedures and mechanisms which are designed to ensure the quality and availability of health care services to all individuals.

S. 2114

S. 2114, introduced by Senator Proxmire on February 27, 1986, would fund studies of patient outcomes from medical and surgical techniques that have been shown to have wide variations in use in different geographic areas. The results would be considered as a tool to reduce health care costs.

S. 2331 (H.R. 3210)

On April 17, 1986 Senator Heinz introduced S. 2331, "The Medicare Quality Protection Act of 1986". This bill is designed to improve the quality of hospital inpatient services under PPS and ensure greater access to post-hospital services. The Senate cosponsors are Senators Glenn, Durenberger, Kennedy, Bradley, Chafee, Matsunaga, Chiles, Wilson, Riegle, Moynihan, and Dodd.

S. 2331 was developed as a response to problems identified during hearings of the Senate Aging Committee in the fall of 1985, i.e. that some Medicare patients were being released "sicker and quicker" from PPS hospitals without adequate resources to meet their post-discharge care needs. (26) Provisions of the bill aim to address problems in three areas.

1. Protect Quality in Acute-Care Settings -- To reduce the risk of patient out-of-pocket costs, the bill would coordinate the period for beneficiary appeal after a discharge notice with the same three day period that the PRO is given to review the appeal. The bill would require that a written notice be given to the beneficiary with information regarding Medicare payment for services, beneficiary financial liability and appeal rights. The bill would permit civil monetary penalties to be assessed against physicians and hospitals who participate in incentive plans that involve a payment for meeting specific per-case, length-of-stay or cost targets. The bill would require HHS to conduct two studies by January, 1988 -- development of a refined classification system that adjusts for variations in severity of illness and case complexity among patients within each payment category, and an assessment of whether the current method of

including payments for administratively necessary days (payments to hospitals for extra days of care when a patient must wait for placement in a SNF) should be changed. The bill would require a report to Congress within 2 years on the adequacy of existing quality assurance standards for participating hospitals (known as the conditions of participation).

2. Improve Access to Post-Hospital Care -- The bill would require discharge planning as a condition for hospitals to participate in the Medicare and Medicaid programs. It would require clear guidelines for Medicare payment for home health and SNF care and provide protection for providers who serve certain ineligible persons by making permanent the favorable presumption of waiver of liability permanent. (This provision permits a SNF or home health agency to be paid for a small number of cases later found to be uncovered or medically unnecessary provided the entity could not have known the payment would be disallowed. The provider is presumed to have acted in good faith if its total denial rate falls below certain levels.) The Secretary is directed to develop a uniform assessment instrument to assess post-hospital care needs within one year and recommend whether this method should be used as

a basis of payment. The Secretary also is required to conduct an annual evaluation of the procedures for assessing quality and access. The provider would be permitted to represent the beneficiary in certain cases that are appealed.

3. Expand the PRO Scope of Work -- The PRO review of quality of care would be extended to post-hospital settings such as home health agencies and SNFs. Review would be intensified in the hospital setting by extending the criteria for review of readmissions to 31 days instead of the current 15 days. The bill would also add a consumer representative to the PRO board, and strengthen review of patient complaints.

S. 2494

On May 21, 1986, Senator Bradley introduced S. 2494, a bill which would modify limits on Medicare payments for home health services and to assure that all legitimate costs are included in the limits. The bill would mandate hospital discharge planning and require Medicare rules to follow the Administrative Procedures Act. Senators Heinz and Glenn are co-sponsors.

FOOTNOTES

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26. Senate Aging Committee, Op. Cit.

Appendix A

ATTENTION MEDICARE PATIENTS ...

A MESSAGE FROM MEDICARE

YOUR RIGHTS AS A MEDICARE HOSPITAL PATIENT.

- You have a right to receive all of the care that is necessary for the proper diagnosis and treatment of your illness or injury. You should stay in the hospital as long as it is medically necessary.
- You have the right to be fully informed about decisions affecting your Medicare coverage or payment for your hospital stay. Do not accept statements that you must be discharged because your "DRGs are up" or your "Medicare days have run out."
- You have a right to appeal written notices you receive from the hospital or Medicare that Medicare will no longer pay for your care (that is, ask for a review or reconsideration of such a notice, if you do not agree with it).

TALK TO YOUR DOCTOR FIRST

You and your doctor know more about your condition and your health care needs than anyone else. Therefore, if you have questions about your medical treatment or your need for continued hospital care, consult your doctor first. If your doctor discharges you from the hospital, the decision is between you and your doctor. Medicare does not interfere in that decision. If you have questions or concerns about hospital services, you should talk to the hospital patient representative or social worker. Don't be afraid to ask questions.

PEER REVIEW ORGANIZATIONS

Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal government to review hospital treatment of Medicare patients. They are responsible for seeing that Medicare patients receive all the hospital care and only the hospital care that is necessary for their illness or injury. Also, PROs will respond to your request(s) for review or reconsideration of hospital notices stating that Medicare will no longer cover your hospital stay.

The name, address, and phone number of the PRO for this hospital is shown at the bottom of this notice.

WHEN TO CONTACT THE PEER REVIEW ORGANIZATION

If this hospital or the PRO decides that you no longer need care in the hospital, they must notify you in writing. This written Notice of Non-Coverage must explain why you no longer need hospital care; it must be given to you at least 2 days before the hospital can begin charging you for the care; and it must explain how you can appeal the decision.

You do not have to leave the hospital in order to appeal a Notice of Non-Coverage. However, you or your representative should write or call in your appeal within 2 days of receiving the Notice. Then, the PRO has 3 working days to complete its review of the decision and give you a written reply. NOTE: If the PRO agrees with the hospital that your care is no longer covered under Medicare, you may have to pay for the care beginning with the 3rd day after your receive the hospital notice.

For more information about your appeal rights while you are in the hospital contact:

XYZ PEER REVIEW ORGANIZATION, INC.
123 MEDICAL REVIEW AVENUE
ANYWHERE, U.S.A.
(301) 594-1662

12/19/85

Senator DURENBERGER. This hearing was called by the Finance Committee Chairman, Bob Packwood. He regrets that he cannot be here with us today, but he sent me with his button. He is working to continue the drive on another issue which is critically important to the elderly as well as to the disabled and the public—that of tax reform.

Bob has a prepared statement that will be inserted in the record in its entirety, including all of the references to the unique demonstration program that he started in Oregon for national averaging on DRG's. [Laughter.]

Senator DURENBERGER. The Federal Government's commitment to health care has traditionally centered around two primary national objectives, that of assuring access to health care and high quality health care for all Americans.

Twenty years ago, Congress established Medicare as a way of delivering on that commitment for this country's elderly and disabled; but in the year 1966, the first year of Medicare, our definition of quality was quite different from what it is today. In fact, by today's standards, access was given much greater emphasis than quality in a system that was often characterized by long stays in the hospital and patients who were examined but not treated and cared for but not cured.

In the past 20 years, however, advances like intensive care units and amazing new diagnostic tools, pacemakers, bypass surgery, cancer therapies, and same-day cataract operations have changed the definition of quality medical care for all Americans.

For the elderly and disabled, in particular, the hospital is no longer simply a place to convalesce or to die. Now, thanks to advances in medical science, the hospital can be a place to renew and even improve life.

With all these advances in modern medicine, however, have come new challenges. New more expensive procedures and devices, when combined with Medicare's financing arrangements, resulted in better access to effective care to beneficiaries; but it also resulted in tremendous increases in costs for both beneficiaries and for the American taxpayer.

The Medicare money machine very naturally led hospitals, doctors, and their patients to think that more medicine was automatically better medicine. Eventually, concern rose among many Americans that the more-is-better practice standard was not only too costly but also might mean too much medicine, particularly in the case of expensive hospital services.

These concerns led to a traditional regulatory response on the part of the Government with certificate-of-need legislation and the genesis of the professional standards review organizations and, later, the peer review organizations which I helped to develop. Action on the regulatory side, however, was only part of the answer. Payment reform had to be the major driving force to bring incentives for providers in line with the actual needs of the beneficiaries.

The advent of per-case pricing for hospitals in 1983, payment by diagnosis-related groups, replaced the traditional cost-based payment system and brought with it a new day in hospital care for Medicare and millions of Americans it served.

Now, instead of more is better, the new Medicare payment system sends doctors and hospitals a signal that patient care should be managed carefully and that patients should receive only the care that they need. And these significant reforms are working largely as intended. Hospitals and other providers have responded well. The new system has given the Medicare Hospital Trust Fund a new lease on life, and it has given efficient hospitals the ability to make the profit margins necessary to maintain their future financial viabilities.

The signals of the new Medicare payment system have been clear to hospitals and doctors, but they have not been as clear to the elderly and to the disabled Medicare beneficiaries. Many patients have been confused about what quality can mean when they are directed away from traditional hospital settings for treatment or for discharged after short hospital stays.

And many older Americans are concerned that the new payment systems leaves the potential for providers to short sheet patients on quality. These concerns have led at least some older Americans to conclude that they may be worse off under the new Medicare philosophy than they were in the past.

We must now confront the risks of an approach which seems to be saying that less is better. The Finance Committee and its Health Subcommittee are indebted to our distinguished colleague, Senator John Heinz, and his Select Committee on Aging, for the very appropriate leadership that they have taken in monitoring the reaction of elderly Americans to changes in doctor and hospital behavior as a result of the new Medicare payment system. His, these, and other concerns which have been raised about the effect on quality of recent Medicare changes are at the heart of today's hearings.

To put it quite bluntly, we want to know whether and to what extent hospitals are short sheeting elderly patients. One often cited indicator of lower quality is the estimated 3,000 to 4,000 premature discharges of Medicare patients identified since 1983. Witnesses this morning will report differing interpretations of the early discharge issue. I am sure we will hear some discussion and debate about how high or low the actual numbers of discharges are, but we must be careful to sort out the extent to which early discharges actually reflect the systematic reduction in quality of care for Medicare patients.

The hearing will, therefore, focus on three critical issues. First, are these 3,000 to 4,000 early discharges the tip of a quicker and sicker iceberg? Or are they exceptions to the rule of generally good medical practice? Do we even have the ability to answer that question? Can we, in other words, answer with facts this critical question?

Second, how much of the concern over premature hospital discharges can be attributed to the fact that DRG's changed the practice of medicine overnight, while all of us forgot to tell the beneficiaries what was going on? Before 1983, Medicare patients could expect to stay in a traditional hospital setting until they were completely recovered. This meant that many hospital stays included what one might call social days or days during which the patient didn't actually require acute care but couldn't arrange for or couldn't afford the less intense hospital care actually needed.

So, the patient stayed in the hospital, and the hospital sent the total bill, including the cost of the social days, to Medicare's Hospital Trust Fund. Now, however, hospitals have no incentive to encourage either inappropriate admissions or longer than necessary stays; and PRO's won't allow either. Medicare now pays hospitals only to care for people who actually need hospital care, not for people who can and should be treated in less expensive but still appropriate settings. Thousands of older Americans, for example, are having cataract and other types of surgery in same-day surgery centers; and thousands more receive cancer-fighting chemotherapy treatments in outpatient departments and increasingly in their own homes. All Americans are having to get used to these kinds of changes in the practice of medicine.

Mothers no longer spend 5 days in the hospital resting up after the birth of a baby; and dozens of tests and other procedures which used to require hospitalization are now done routinely in doctors' offices all over America.

Third, how much of the concern over premature hospital discharges is really a concern over patients' inability to find the nonhospital settings or the posthospital care that they need? As I have said, Medicare's new payment system means patients will be admitted to a hospital only when hospitalization is needed and discharged from the hospital as soon as hospitalization is no longer necessary. In the days of cost-based reimbursement, Medicare paid the cost of convalescent care when it paid all the hospital days the doctor ordered. Now, Medicare has made clear that this type of care must be provided outside the expensive hospital setting. Yet, Medicare hasn't changed its posthospital care structure. This leads one to logically ask the question: Should Medicare now pay more of the share of posthospital care, particularly since the burden of that care has now increased? My tentative answer to that question is "Yes," but we haven't yet conformed the payment system for nursing homes, home health, and other alternatives to ease the burden of choice on the patient and the doctor.

As I read the testimony that was submitted for this hearing—with these three issues in mind—I was struck by the work of the General Accounting Office and the Office of Technology Assessment. These two agencies did not conclude that there was a quality problem, but they didn't conclude that there was not a quality problem either. Instead, they concluded that there is, amazingly enough, no data with which to demonstrate clearly whether there is a quality problem with the new Medicare payment system.

That conclusion leads me to call for united effort to get the information we all need to really answer the questions asked by today's hearing. I understand Blue Cross-Blue Shield is establishing a nationwide computerized information sharing network which will cover 80 million people. I am sure there is much the Federal Government can learn from this kind of a national data network. In a letter to Secretary Bowen, John Heinz and I have already expressed concerns about specific problems with the administration and organization of Medicare data which inhibits its usefulness to the evaluation of the effects of major policy changes on Medicare beneficiaries.

Similarly, to my knowledge, HCFA has made no systematic effort to create a usable PRO research data base. Therefore, PRO's do not perform their reviews in a way which allows the data to be analyzed to identify regional variations of treatment patterns or to conduct national evaluations using objective measures of the quality of care.

In order to begin to remedy this situation, I intend to introduce next week legislation which would help fill the critical gaps in our current knowledge of the needs of Medicare beneficiaries and the quality of care that they are receiving. That legislation, the Medicare Information Act of 1986, will implement several of OTA's recommendations and those we hear today for improving the usefulness of existing and future Medicare information. The legislation will create a new Medicare quality barometer system, or QBS, to provide both administrators and policymakers with the kind of information they need to address the issue of quality care without dependence on anecdotes and estimates.

And this legislation will take a longer view beyond the immediate quality questions raised by DRG's. It will help Medicare to buy value for its beneficiaries by establishing a program to study the health outcomes of Medicare patients who undergo procedures for which utilization varies.

Such studies are essential if we are to understand better how to determine which and what level of care is really the best care. And they are essential as we move from ensuring quality and accessibility through Government insurance and regulation to the era of consumer choice of private health plans and the reliance on the skills, plus the economic incentives, of health providers. And finally, I would like to take this opportunity which representatives of all segments of the health care delivery system are together here, to remind all of us that quality isn't an issue which can be resolved by one hearing, one bill, or one piece of legislation.

A reporter asked me the other day if I had introduced any quality bills. My answer was that every bill I have authored addressing health care reform is a patient quality-of-care bill; making sure that health care is more cost effective means getting better quality through wiser use of financial and medical resources; but in meeting this obligation, hospitals and doctors cannot be shortsheeted any more than can patients. Ensuring quality care, in other words, means making sure that money isn't arbitrarily taken out of payments to the hospitals for capital or out of physicians' fees. And it means that hospitals and physicians must be given the correct economic signals to protect quality of care for beneficiaries.

Across-the-board freezes, uniform DRG adjustments that fall way below the increases in costs are not consistent with meeting this obligation to ensure quality for all elderly or disabled Americans.

We are fortunate to have with us today a distinguished set of witnesses to help us explore both concerns about the effect of the current Medicare system on quality and the adequacy of present information. We are also very fortunate to have with us a distinguished group of my colleagues, and I think in the order of their appearance, George Mitchell is next.

Senator **Mitchell**. Thank you, Mr. Chairman. I appreciate your scheduling this hearing to examine the quality of care under the new Medicare payment system. Since the implementation of the system in 1983, we have seen significant changes in the way Medicare reimburses the hospitals.

In an effort to assure that the method of payment did not compromise the quality of care of patients, safeguards were built into the system. The most significant of these safeguards is the peer review process. Congress intended for the PRO to serve as the check on quality of care for elderly beneficiaries under the prospective payment system. Does the peer review organization process really serve as a check on the quality of care for the elderly under Medicare?

There is much evidence that it has become primarily, if not exclusively, a cost payment measure whose goal has little or nothing to do with protecting the patient but much or everything to do with reducing the cost of the Medicare Program. Congress must work to assure that PRO does what we intended for it to do. Beneficiaries are, in fact, being discharged quicker and sicker. Should we not regard the PRO as not functioning in the manner intended by Congress?

Before we act to reform existing law, we must assure that the programs designed to assure quality of care under that law are being implemented as Congress intended.

As a Senator from a rural State with long, cold winters, I am particularly concerned about access to care and quality of care for those who live in rural areas. We must pay close attention to those in our States with the additional burdens of distance and climate and consider reforms to the prospective payment system that would allow for those factors in making admissions and discharge determinations.

Mr. Chairman, I regret that I must leave to attend another hearing, but I look forward to reviewing the testimonies presented this morning, particularly from Dr. Roper. I will have a fairly long list of written questions for Dr. Roper, and I would like to get the answers as soon as you can conveniently do so. As you know, Dr. Roper, from our private discussions, I am deeply concerned about the PRO process nationwide and, of course, specifically in my own State of Maine, where the PRO organization is from another State; and this has caused widespread dissatisfaction in the medical community in Maine.

You are from Alabama. Now, how would the doctors of Alabama feel if a group of people from Maine conducted the review of their process and their procedures? I don't think they would like it. When Dr. Bowen was nominated, he came in for a meeting in my office before his confirmation; and I asked him how the doctors in Indiana would like it if a group from Texas were conducting an overview of their process. Oh, he said, that would be terrible; I don't think the doctors there would like that at all. Of course, nothing has happened since then.

So, I feel very strongly that this process is not working, and it is particularly not working in the instance of a State like mine where the medical community of the State has little or nothing to say about the process by which the review of its procedures is occurring. I don't know if there are any other States in a comparable situation, but if there are, then I think it ought to be changed. I have a number of questions for you on the program nationally and on that specifically; and I hope we can work together to improve the prospective payment system, to eliminate whatever shortcomings it has and to keep in mind the original purpose of the whole program, that is to provide quality medical care to all of our Nation's elderly.

I know that is your objective. I want you to know that it is my objective; and I am sure it is the objective of all members of this committee. Thank you very much, Mr. Chairman.

Senator DURENBERGER. George, thank you very much. Chuck Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman. I, too, have to beg your indulgence because I am going to be chairing a hearing of my Subcommittee on Aging, and it is on the issue of the Census Bureau's inability to have a statistical base to predict what might be problems that we face with an aging population as we go into the next decade and into the next century.

But for the immediate, your hearing, I would have to say, is even more important. It is similar to hearings that I held in Iowa with just an Iowa constituency on similar problems last August; and we have had witnesses in previous hearings express a great deal of concern that I am sure you will be hearing today on the lack of patient information for Medicare beneficiaries on how the prospective payment systems and particularly on their rights of appeals.

Most of us in Congress hear daily from constituents that don't comprehend the system and wonder what has happened to their Medicare hospital services protection. At the minimum. I would say that we ought to have HCFA and our peer review organizations do a better job in educating not only patients, but providers as well. We hear the words always repeated that people are being discharged from hospitals quicker and sicker. I don't know whether there is a mutual agreement that that is the case, but at least it keeps coming up quite frequently in our hearings.

I would suggest that even more at risk are those Medicare patients with heavy care needs who are released to their homes and communities that lack programs of comprehensive community-based care, where we tend to be concentrating to a great extent on just the problems of nursing homes being ill equipped to address heavy care needs of people who are immediately out of the hospital.

Clearly, we have to address then the limitations on access to skilled nursing facilities and the narrow scope of home health care benefits that put a strain on the availability of post-acute care. And yet, another concern is whether the peer review organizations are adequately assuring quality of care for Medicare beneficiaries. One of the most important cost-containment aspects of the PPS system is the built-in incentives for hospitals to both admit patients and to discharge patients earlier.

The PRO's are charged with a difficult dual and often irreconcilable task of utilization, on the one hand, and quality review, on the other. Unfortunately, I think utilization review has taken precedent over ensuring that financial incentives in the DRG system don't result in bad medical judgment and substantial substandard care of beneficiaries. We need to explore how we can obtain better quality of care review, both in acute care and the continuum of care. Expanding PRO review to post-acute care would help us to know whether patients are being prepared for home care or are experiencing complications for hospital discharge for outpatient treatment.

After about 2 years of this general discussion, Mr. Chairman, and I am sure as a result of your hearings, we are going to eventually have to reach decisions on these issues that we have been mulling over in our minds for so long.

Senator **Durenberger**. Thank you, Chuck. Max?

Senator **Baucus**. Mr. Chairman, thank you for yielding to me. This is a very important time to address quality of care basically because we have undertaken a dramatic change in reimbursement of Medicare from cost-based to the prospective payment system. We now have some experience. We have some time. We are able to look at some results.

This is probably one of the first times we can begin to comprehensively and honestly determine the degree to which quality health care in this country has suffered. There are a lot of questions that many have asked and a lot of good points that many have made. I particularly am concerned about the quality of health care as it applies to rural hospitals.

The main concern I have is that the unarticulated premise of PPS is that the efficient hospitals survive and the inefficient fail and that patients can then go to the nearby efficient surviving hospital. And we all know that that is a bit difficult in rural areas because there is not a nearby efficient hospital, once an inefficient hospital has failed.

It is particularly unfair because the system is biased against rural hospitals in that, due to the large numbers, major hospitals—urban hospitals—with a higher operating cost—a fixed cost ratio—can adjust to patient load changes and adjust to some of the cost problems that are incurred upon hospitals. Rural hospitals necessarily, because of their higher fixed cost to operating cost, fail not because they are inefficient; it is because they don't have the advantage of the large numbers that urban hospitals have.

Therefore, when they fail, patients in those rural areas can't go any place. There are no other hospitals nearby. So, this is a part of the quality of care problem which I am particularly interested in, and I hope that we can flush some of this out during the hearings. Thank you.

Senator **Durenberger**. Thank you very much.

Our first witness will be Dr. Bill Roper, the Administrator of the Health Care Financing Administration. Bill, we welcome you to your first official hearing. Thank you for being here. Your statement, which we had in advance, will be made part of the record. You may proceed to summarize in whatever way you choose.

STATEMENT OF WILLIAM ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY PHILIP NATHANSON, DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION

Dr. Roper. Thank you, Mr. Chairman. I am pleased to be back in this room, a little over a month after my confirmation hearing, and I told the committee that day that this administration is anxious to improve the quality of the Medicare Program. I welcome the opportunity we have today to discuss how that can be done.

In the 3 weeks since I became Administrator of the Health Care Financing Administration, the quality of care provided our beneficiaries has taken more of my time than any other issue. As a physician and as a person whose parent is a Medicare beneficiary, I am concerned about maintaining and improving the quality of care provided in the Medicare Program.

I have discussed quality as a general issue with Secretary Bowen on several occasions during the past 3 weeks, and he shares my commitment to that principle.

This past weekend I went to Florida. I went there to assure our beneficiaries that they come first as we deal with an HMO, International Medical Centers, serving a large number of beneficiaries in south Florida. I am pleased to report, Mr. Chairman, that we have in process an action that will lead to the solution of IMC's problems. This morning, I have a detailed statement which I want to submit for the record, which sets out my views on the issues of greatest concern to us here today relating to post-hospital services.

It represents a detailed description of what HCFA has undertaken in the area of quality. It also presents HCFA's detailed comments on the Medicare Hospital Quality Assurance Act of 1986, which Senator Heinz has introduced with support of other members of the subcommittee.

HCFA's current quality efforts rest on five pillars.

First, on-site protection of providers through the survey and certification process. Second, the peer review organizations, about which I am sure we will hear much today. Third, the efforts of our Office of Beneficiary Services to help Medicare beneficiaries understand their coverage. Fourth, the Office of Health Maintenance Organizations, which recently became a part of HCFA and which will focus on prepaid health care delivered through HMO's. And finally, an extensive research effort which has several projects under way designed to tell us more about how PPS has affected beneficiaries.

I want to begin by commenting on the concept of quality. It is a very important concept, but all too often I think we have acted in accord with Mr. Justice Stewart's famous comment, "I know it when I see it." I am concerned that we need to be more precise about quality. And in that regard, I have asked my research staff to convene a conference this fall along with assistance from other HHS units to try to build greater consensus about how quality can and should be measured.

We plan to gather many knowledgeable researchers, and we hope to begin the process of making judgments about quality which rely on sound statistical inference. The results of this conference will guide our research and policy agendas for the future.

In sum, it is my desire to deal with quality, not on the basis of subjective estimates, but on objective measures of quality. When confronted with the current ambiguity about how we can best measure quality, many observers have taken statistics that pertain to hospital discharge and post-hospital services as a proxy for quality. Those who have formed arguments from these statistics have given us the slogans of the current debate: "Quicker and sicker," "A no-care zone," and so on.

Many of the phenomena cited by these slogans are temporary. They can be explained by the dislocation that accompanied the introduction of the prospective payment system. For example, two minor parts of hospitals—at least formerly they were minor parts of hospitals—became much more significant. Hospital records departments became extremely important in deciding how much a hospital is paid by Medicare when they code for diagnosis. Discharge planning, similarly, went from being a cost to becoming an integral part of cost control efforts as it showed its ability to help reduce length of stay. Building capacity in both these areas has taken time. The peer review organizations did not start operation until the end of the first year of PPS, and several PRO's were delayed even more by data problems and other start-up delays.

Further, when PPS was introduced, it was not perfectly understood at the outset. Erroneous phrases like "Your DRG is up" began to appear across the country; but, over time, provider and beneficiary understanding has greatly improved.

While many of the problems we have had reported to us can be described as part of the transition to PPS, there remains a part which is inherent in the way prospective payment works. This problem is based on the fact that Medicare is a defined benefit insurance program with a focus on acute care. What forms of acute care Medicare covers are clearly spelled out in the law—hospital, skilled nursing facility, and home health care at the acute level. A benefit plan such as traditional Medicare cannot comprehend the idea of a continuum of care.

It is this idea of a continuum of care that inspires much of the uneasiness about posthospital services. The answer to this uneasiness is an alternative to the defined benefit plan. This alternative is capitation. Today, we have providers who are responsible for only their part of the continuum. Hospitals provide hospital care, skilled nursing facilities, skilled nursing care, and so on.

The traditional Medicare payment has been based on the concept that by jiggling various payment rates—paying more for this service or less for that service—we can get the appropriate mix of services: Hospitals, SNF's, home health, et cetera. But under capitated arrangements, there is one entity which is responsible for the whole spectrum of care. These entities have both the responsibility and the incentives needed to provide needed care in the most cost-efficient setting.

In the areas where there are already a large number of beneficiaries involved in capitated payment through HMO's, as in your own home State of Minnesota, Mr. Chairman, these are also places where complaints about the current lack of continuum of care are the smallest. It is the ability of capitation to meet beneficiary needs better than the current defined benefit plan that makes me so excited about the future of the Medicare Program.

Under capitation, there would be a "seamless benefit," if you will—no cracks for beneficiaries to fall through. But we are not blind to the problems that are inherent, at least potential problems, in capitation. I think the steps we are now taking to deal with the problems of our largest Medicare HMO in Florida, IMC, bear witness to that fact.

In closing, I want to reiterate my personal commitment to both making existing mechanisms work and building the alternative delivery systems that will provide real solutions to the problems we confront here today. I hope to have the support of all the members of the subcommittee in this effort.

This concludes my statement, Mr. Chairman, I look forward to an exchange of views with you and other members. Thank you.

[The prepared written statement of Dr. Roper follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

JUNE 3, 1986

INTRODUCTION

Mr. Chairman and members of the Committee, I appreciate this opportunity to discuss current concerns about the quality of care provided under the Medicare program. I am strongly committed, as is this Committee, to the goal of quality care and will take whatever steps necessary to assure that goal is achieved. Since I became the Administrator of HCFA -just over three weeks ago - much of my time has been spent on the quality issues before this agency. Secretary Bowen and I have spent time shaping the agency's budget to direct emphasis on quality. I have also been meeting with my senior staff over the past few weeks to look closely at our current quality safeguards, to identify any potential problems that may exist and, where they exist, to begin to develop a strategy for closing any gaps. To further enhance the ongoing HCFA quality effort, I plan to convene a conference this fall on measuring quality of care. The conference will focus on developing a methodology to measure quality of care. This is a necessary first step in order to accurately come to grips with this important issue and aggressively implement programs to guarantee high quality care for all Americans. I will gather the foremost experts in the quality of care field to advise us in this critically important area and I have directed that these people be identified and contacted.

I would like to preface my comments today by saying that I am convinced that the Health Care Financing Administration is going to continue to aggressively address the issue of the quality of care provided to Medicare beneficiaries. I am not satisfied that we have done all that we can do. I am concerned not only about how well we are assuring quality for the Medicare population as a whole; but I am also concerned that not one beneficiary suffer for lack of care that should have been provided under Medicare or as a result of poor quality care.

My prepared statement has three parts: first, a brief discussion of my concept of the Medicare program's responsibilities and the concerns about quality that are foremost in our minds at this hearing; second, a detailed discussion of what HCFA is currently doing to assure quality and our plans for the future; and third, an attachment detailing our position on Senator Heinz's bill, S. 2331, "The Medicare Quality Protection Act of 1986."

As you know, Medicare was created as an insurance plan to meet the acute care needs of our Nation's elderly. The statute provides for coverage of acute hospital care and post-hospital extended care services, limited to the provision of skilled services in a skilled nursing facility or in the patient's home through a home health agency.

Medicare patients are appropriately discharged from the hospital earlier, but this is a process that began before PPS. Just as before, patients are in a medically stable condition when discharged, but may still require some care to assist them with activities of daily living, such as bathing or preparing meals. Care of this nature is not considered skilled and is not covered by the Medicare program.

The Administration has proposed to increase the opportunity for beneficiaries to enter comprehensive health care delivery systems paid on a per capita rate. Under capitation, providers furnish a continuum of case-managed care, frequently with a larger benefit package than available under the traditional Medicare program, for the same or slightly higher cost.

Let me briefly outline for you the major mechanisms used to assure that beneficiaries receive quality care, then I will expand on each of these and give you an overview of our goals for further progress in this area.

QUALITY MECHANISMS

There are five major mechanisms that HCFA utilizes to ensure quality:

- o We perform on-site inspection of Medicare providers to ensure that basic health and safety standards are met and that providers are "capable of providing quality services."
- o We have Peer Review Organizations which review in-patient hospital care provided under Medicare to assure that it is medically necessary, delivered in the appropriate setting and meets professionally recognized standards of care.
- o We have recently brought within HCFA the Office of Health Maintenance Organizations which ensures that an HMO meets Federal qualification requirements before it can participate in the Medicare program and monitors the HMOs to ensure continued compliance with these requirements.
- o We have an Office of Beneficiary Services which ensures that beneficiaries understand their Medicare coverage and their rights under the program.
- o And, finally, we have an extensive on-going research effort that is focusing on the impact of the prospective payment system (PPS) on quality and exploring ways to refine PPS to ensure that facilities are adequately compensated for care provided the most severely ill.

SURVEY AND CERTIFICATION

As I mentioned, a major component of our quality assurance program is the survey and certification process which has been in place since Medicare was originally enacted. This activity protects the health and safety of individuals in every type of health care facility participating in the Medicare and Medicaid programs. We devote a large measure of our resources, about 10 percent, to support the activities of approximately 3,000 State surveyors nationwide. There are about 350 Federal staff, 275 of which are located in our regional offices, to oversee and insure the effectiveness of this process.

Under contract with HCFA, State agency surveyors inspect providers to determine the extent and degree to which each facility is in compliance with the regulatory requirements, and to obtain an overall evaluation of a facility's performance and effectiveness in providing appropriate and safe patient care. Identified problems result in a statement of deficiencies for which the facility must submit a written plan of correction. This information is the basis for conducting follow-up or monitoring surveys to ascertain progress and assist the facility in carrying out its care requirements. If the facility has more serious compliance problems, it is terminated from the Medicare program. Because it can limit access to care, termination is the last resort, but we will not hesitate to exercise our authority and terminate facilities which do not provide consistently high quality of care. During fiscal year 1985, for example, 71 hospitals and 133 SNFs were terminated from participation in the Medicare and Medicaid program for lack of compliance. In order to expedite the termination of substandard facilities we implemented revised termination procedures in December, 1985. These new procedures will accelerate the process for terminating facilities with immediate and life-threatening situations and set time limits for all steps in the termination process.

Although the current survey system has had a high degree of success in assuring appropriate care in a safe environment it is primarily focused on the facility itself -- is the building in good repair, are the rooms large enough, are doors wide enough to permit entry of wheel chairs, etc., and on staffing and written policies. This focus assumes that if the structures are safe, if qualified staff are properly utilized and if appropriate processes are in place, good care will be provided.

In other words, the current survey process has had limited focus on the patient. We believe that the focus rightly belongs on the patient -- have their needs been assessed? have services been ordered by their physician to address those needs? have these services been delivered? And finally, what is the outcome of the delivery of services? We have revised the survey process for nursing homes and are about to implement a new survey tool, the Patient Care and Services (PaCs) assessment, which will enable us to answer these questions for patients in these facilities. Among other activities, this innovative survey tool will:

- Provide an indepth review of care - this review will be accomplished through actual observation of the care being provided;

- Evaluate facility food service - are meals dietetically appropriate? are they served attractively and at appropriate temperatures? is assistance provided when needed? and

- Evaluation of drug administration - are drugs administered according to the physician's orders.

A notice of proposed rulemaking was published in the Federal Register on October 31, 1985, providing the opportunity for public comment on this tool. The final rule should be published in the near future. Although this new survey process will still ensure compliance with all Federal health and safety requirements, PaCs is an innovative, patient-centered survey system which will also provide a more valid estimate of the quality of care furnished by the facility.
We are confident that this new process will improve our ability to assess quality of care.

We plan to expand our efforts in outcome-oriented surveys and are developing patient-centered survey tools for home health agencies, end stage renal disease facilities, psychiatric hospitals and intermediate care facilities for the mentally retarded.

We have also undertaken a major revision of the requirements hospitals must meet in order to provide care under the Medicare program. One of The primary purposes of these revised conditions of participation is to strengthen patient health and safety requirements.

We have included in this revision, a new condition that will require the hospital to establish a hospital-wide quality assurance program aimed at identifying and correcting patient care problems. Hospitals will be required to evaluate all medical and surgical services and take appropriate remedial action, documenting the outcome of that action. In addition, we feel strongly that appropriate discharge planning is essential to total patient health and that this is a function that a hospital should provide. Therefore, the quality assurance condition will also require hospitals to have an effective, ongoing discharge planning program to facilitate the provision of appropriate post-hospital care.

We have also expanded the survey process for home health agencies to include visits to the homes of patients receiving home health services. Here again, in the past the home health survey activity was focused on the agency itself - was the agency capable of providing services. Now, visits to beneficiaries in their homes will allow the surveyor to:

- Talk to the patient and the patient's family about the care being received, and;

- Verify that care conforms to the physician's orders and is provided according to the plan of treatment.

This is an important step to assure that home care patients are receiving appropriate and high quality services.

PEER REVIEW ORGANIZATIONS

In passing legislation to reform the Medicare hospital payment system in 1983, Congress presented an enormous challenge to our Department in the implementation of the prospective payment system. One of the most crucial objectives throughout the payment reform process has been to maintain the quality of and access to care for our beneficiaries. The potential for unique problems in quality of care under PPS, in part, motivated the Congress to strenghten the peer review process.

During the first PRO contract period, the emphasis was placed on the potential negative impact that reimbursement incentives in the PPS could have on quality and utilization. PROs were directed to review admissions, readmissions, transfers and outliers and to focus on possible premature discharge. All PROs were required to identify area-specific utilization and quality problems and to address these problems through achievement of objectives. These objectives also provide a way to measure PRO performance and effectiveness.

Just as we continue to monitor and refine the PPS to ensure that payment levels support delivery of high quality care, we must also continue to monitor and refine the PRO quality assurance program. This medical review system is a complex, dynamic system and we have learned much during the first two years of PRO review. We are using this experience to refine PRO review in order to further assure that Medicare beneficiaries receive high quality, medically necessary care in the appropriate setting.

What did we learn during the first PRO contract period and what is our future direction in continuing to assure quality of care? Briefly, we learned that we needed:

- To redefine PRO efforts in all areas of quality review;
- To expand our review in the area of premature discharge;
- To further focus PRO review on poor performing providers and practitioners; and
- To expand our efforts to assure that beneficiaries and their families understand their rights.

And we have aggressively addressed each of these issues. We have expanded the PRO's Scope of Work for the 1986-1988 contract period to require PROs to subject every case they review to a generic quality screen to look at:

- The adequacy of discharge planning - were arrangements made for necessary care and services upon discharge?;
- Medical stability at discharge - were the patient's temperature and other vital signs normal?;
- The presence of nosocomial infections - did the patient acquire an infection while in the hospital?;
- Trauma suffered in the hospital - did the patient suffer a fall in the hospital?;
- Unplanned return to surgery - was the patient returned to surgery to correct an operative problem?; and

- Deaths - was the death during or following surgery? was a death on a regular floor unit unexpected?

PROs will also continue to review all transfers to other hopitals and exempt units to identify problems with inappropriate transfers. Review of readmissions has been expanded to all readmissions within 15 days of discharge instead of 7 days as required in the first PRO contract period. We believe that review of readmissions within 15 days is the most appropriate timeframe within which to determine whether a problem exists within a facility. Although review for a period beyond that might pick up additional readmissions, we do not believe that it would identify more facilities that have a systemic problem. Instead, we would begin to see cases of appropriate readmission for chronically ill patients.

Over 10 percent of all PRO review will be intensified review of providers that are poor performers or in response to identified problem areas. In all cases where a PRO finds poor quality, corrective action will be taken, ranging from education of the individual physician or hospital, to intensified review, to payment denials and ultimately to exclusion from the Medicare program.

Provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) expanding the PROs' authority to deny payment for poor quality care will further increase the effectiveness of PROs. We will be meeting with a physician panel in July to discuss appropriate guidelines and crieria for denial payment for substandard care and expect to implement this provision by October of this year.

Another COBRA provision requiring PROs to perform 100 percent pre-procedure review of at least 10 elective surgical procedures performed on an inpatient or outpatient basis, will further assure that Medicare beneficiaries are not subjected to unnecessary surgery. We will be consulting with physician groups this summer to determine what procedures to subject to this review. We expect to implement this program in January, 1987.

A continuing concern of both Congress and the Administration has been the potential for premature discharge under PPS. We share this concern and as I just indicated, the new PRO scope of work will enable us to address this issue more effectively. The Medicare program emphasizes that patients should remain in the hospital until they are well enough to be released. We do know that there have been cases of premature discharge and we investigate each case and take appropriate action. Even one case of premature discharge is too many and we are committed to the strongest possible action, based on the circumstances of each case, when we learn of any instances of poor quality care.

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS

The move toward capitation through HMO participation in the Medicare program is an historic turning point. It marks a decisive move away from intrusive regulatory schemes for controlling costs to an approach that utilizes increased competition and consumer choice. The Secretary's recent transfer of the Office of Health Maintenance Organizations to HCFA appropriately places their on-going, HMO quality assurance mechanisms under the same organization as the Medicare program.

As part of the requirement for Federal certification, HMOs must have a quality assurance program which stresses health outcome. The Office of Health Maintenance Organizations monitors these plans to assure that this program is in place and functioning. In addition to this traditional regulatory method of monitoring quality, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provided a market based approach. To qualify for a contract with Medicare, a HMO must also have at least 50 percent of its enrollment in commercial business. This provision assures that an HMO can demonstrate its ability to meet the rigors of the market before it is eligible to enter into a contract to provide services to Medicare enrollees.

To be able to attract and retain commercial business, the plan must demonstrate that it:

- Can deliver high quality services;
- Has effective medical and financial management; and
- Has good relations with the provider community.

If a plan cannot meet the demands of the market, it cannot enter into a contract with HCFA. This requirement provides a non-intrusive incentive to maintain high quality care. In addition, COBRA requires the review of the quality of services furnished by HMOs. The HMO industry is in the process of developing its own quality assurance capabilities. We support this concept and we have begun a discussion with a number of these organizations to provide assistance and support for a private sector approach.

OFFICE OF BENEFICIARY SERVICES

Another area that has concerned us is beneficiary education about PPS, PRO review and the rights of patients to an appeal. Since the implementation of PPS, we heard from Medicare beneficiaries and their families that they had been told that a patient must be discharged from the hospital once the "DRG is up" or because their "Medicare days are up." Clearly, this is not the case. The PPS system is based on payments which, on average for a DRG, will be adequate to cover the utilization of services. Some patients will have stays below the average, others above it. It is the responsibility of the hospital to provide all necessary services regardless of the length of stay.

In order to increase beneficiary understanding of this fact, we have instructed all hospitals to give beneficiaries information upon admission about their appeal rights. In late February, a letter "An Important Message From Medicare" was provided to all fiscal intermediaries for distribution to Medicare providers who must give it to beneficiaries upon admission. We have instructed PROs to monitor hospital compliance with the distribution of this information to beneficiaries. In addition to this beneficiary letter, we are revising and consolidating the pamphlets which explain the appeals provisions under Medicare. We are also developing a new pamphlet to better educate Medicare beneficiaries and their families regarding hospital stays under PPS. The 1986 edition of Your Medicare Handbook has already been revised to include additional current information on a number of relevant topics, including appeal rights, PPS and the role of the PRO. We have issued "Medicare/Medicaid Notes" to beneficiary groups to explain, among other topics, PPS and their appeal rights. We are also providing these "Notes" to the Administration on Aging for distribution to their Area Agencies on Aging.

Finally, we have included in the 1986-1988 PRO scope of work a community outreach program to help beneficiaries understand the role of the PRO and their appeals rights. We will also continue to work with groups interested in developing informational publications on the appeals process. We will continue to use every avenue available to us to assist our beneficiaries in becoming their own best advocate.

RESEARCH EFFORTS

We also have many research activities in the area of quality. One of these studies, being conducted by our Office of Research and Demonstrations, focuses on the effects of PPS on a broad range of patient care outcome and hospital utilization indicators. Among the indicators being studied are: discharge rates, hospital days of care rates, length of stay, population-based mortality rates and post-admission mortality rates.

We have contracted with health care research firms for completion of four other research projects:

- A study by the Commission on Professional and Hospital Activities to measure the general effects of PPS on the quality of inpatient hospital care, primarily by examining changes in hospital usage and treatment patterns and their effects on inpatient and discharge status;
- Two studies by the Rand Corporation:
    - A study to evaluate the impact of PPS on the quality of care by assessing potential effects on changes in inpatient hospital treatment patterns through a thorough examination of the medical record, and resultant health status outcomes; and
    - A study to develop improved methods for monitoring hospitals on an ongoing basis.
- A study by the Urban Institute to evaluate PPS quality impact on ESRD Medicare beneficiaries, a subset of the Medicare population generally assumed to represent an unusually high medical risk group.
- A study by Duke University and the Urban Institute of changes brought about by PPS on the use of Medicare services by the chronically impaired elderly, a sub-population who may be in particular need of post discharge services.

Additional quality of care studies include:

- A study by the Northwest Oregon Health Systems, currently underway, to develop a method for measuring patient health status at the time of hospital discharge. This study will help us understand the functional status of patients at discharge and give us some insight into the type of patients who may require post-hospital care and the level of this need. While the instrument is not intended as a patient management tool, it may ultimately be used to determine the impact of PPS on the health status of patients at discharge, and;
- A major study is also being planned by HCFA, in coordination with the Assistant Secretary for Planning and Evaluation (ASPE), to determine the need for post-hospital services and the availability of these services. This study would look at the appropriateness of post-hospital care services, potential barriers to these services, program and benefit costs as well as out-of-pocket costs for beneficiaries.

There has also been concern about the need to adjust the PPS payment rate, under diagnosis related groups (DRGs), to account for severity of illness. In developing the payment rates, we took into account data approximating the cost of medically necessary care for classes of patients with unique conditions through the use of DRGs. Outlier payment provisions were made for extremely long stays or high cost cases. We do, however, have underway several studies focused on the refinement of PPS. We want to know, for instance:

- If the outlier payment process is sufficient,
- The degree to which DRGs properly account for severity; and
- If there are significant, systematic differences between teaching and nonteaching hospitals in the complexity of diagnoses and severity of illness within DRGs.

Building better measures of severity, however, requires information that is not systematically captured in most hospitals and currently does not exist in national data sets. It should also be noted that the research community is far from consensus about what variables, in what combination, represent patient differences which should be recognized in a payment system. We are committed to maintaining the necessary research emphasis to answer the question of whether severity of illness data can better account for case complexity than the current system.

CONCLUSION

As my brief outline has indicated, activities to assuring quality of services and examining ways to improve quality is a major focus of HCFA. Every family in this country, including my own, is touched by the Medicare program. A major role of HCFA is to assure that the aging and disabled continue to receive high quality care. As Administrator, I am committed to focusing my efforts in this area. I look forward to working with you, Mr. Chairman, and the members of this committee to advance our shared goal of ensuring that every Medicare patient receives high quality, medically necessary care. I will be happy to answer your questions.

Senator **Durenberger**. Bill, there is a chart that is repeated in various parts of this testimony, and I assume it to be factual because it is part of the investigation or research on this issue, that 30 percent of the PRO's had not referred any cases to HCFA for appropriate corrective action in a year and a half. PRO's, it is alleged—in some cases at least—do not correct quality problems when they are found. What is your reaction to that allegation?

Dr. **Roper**. I think the problems you cite are among those that have led us not to renew a number of the PRO contracts. That is why we are working with them to try to improve their efforts in these areas.

Senator **Durenberger**. So, do you have any other way, other than through the PRO, to determine the appropriateness or inappropriateness of the quality of care that is being delivered?

Dr. **Roper**. The PROs are the mechanism that we have at hand. Yes, sir.

Senator **Durenberger**. The PRO's are the only mechanism you have?

Dr. **Roper**. I want to be clear that the basic quality control mechanism is the professionalism of the doctors and hospital managers out there. I think the PRO's are a useful adjunct, but we fundamentally depend on professionals providing quality care. The PRO's are a useful tool, but I don't think we can have medical management by committee, especially medical management by a committee at long distance. So, we are trying to provide assistance and some oversight, but it is not a perfect solution.

Senator **Durenberger**. I think we will find during the course of the morning that some of the experiences of the PRO's will indicate that they see more problems in what they call lack of professional standards on the part of the medical profession than they find premature discharge or that sort of thing. Would that conform to your general knowledge of the contributing factors to the quality of medical care in this country as well?

Not you, of course, in your days, but [laughter].

Dr. **Roper**. If I understood the question, it was what my comment is about, an assertion that lack of professional standards among physicians is the greater contributor to quality problems.

Senator **Durenberger**. Than is the premature discharge from the hospital. That is, if you went across 2 million admissions today and you measured the adverse consequences in quality terms to a patient who had a disease or an injury when they went into the hospital. Would that conform with your own personal judgment, plus your experience in this field, that probably more of the quality problems are attributable to lack of professional standards on the part of a medical practitioner of one kind than a hospital which forced the too-early discharge of a patient?

Dr. **Roper**. That is a tough choice to make. I don't think we suffer in general from a lack of professional standards. I think the idea implicit in that is that we can somehow construct national norms for how to treat patients. For example, in the legislation that created PRO's, Congress had the wisdom to point out that there ought to be locally and regionally generated criteria for making judgments. National norms, while useful in treatment of some diseases clearly understood to have only a single treatment protocol are useful; but in general, I don't think we suffer from a lack of national norms on medical treatment.

Senator **Durenberger**. In a paper that was prepared for this hearing by the Congressional Research Service, they talk about health professionals who have defined measures of quality in three categories: structural, process, and outcome. Structural being facilities and staff, which is usually overlooked by professional associations; process being a set of activities related to patient treatment, such as prescribed medical procedures; and that process is the professional norm or practice.

And what I want to explore, after Max has a chance to ask you some questions, is what your view is or will be on the larger issue of quality—the large issue of quality—because—in fact, I am going to ask you a question that says: From your experience, or that of Phil or anybody else at HCFA, would you not think that, while we perhaps have serious incidents of early discharges—quicker, sicker, that sort of thing—have we not also improved the quality of care of a lot of elderly Americans through the institution of a prospective payment system in which we are doing things to change the professional standards and practice patterns of physicians in America so that they are not taking out tonsils on everybody under 14 in certain communities in this country, or they are not taking out cataracts or doing surgery on eyes that don't have to have surgery done on them?

That they are not doing excessive and harmful intrusions into the bodies of elderly Americans? That is the kind of question I want to ask you later on.

Dr. **Roper**. You said you were going to ask me later, but could I respond briefly now? My conclusion is that quality has improved dramatically, in recent times across our health care system. I think what we are here today talking about are some consequences of the prospective payment system and what the impact of those consequences are. But I, for one, would like to be on the record as saying that it is my judgment that quality in general is better. What we have to deal with is rather like unemployment statistics. Unemployment is down; that is cause for good news and general rejoicing. But as long as there is one person who wants a job and can't have it, we ought not be content. And similarly, we ought to be pleased at the improvement in quality, but as long as there are some problems, we ought to be dealing with them.

Senator **Durenberger**. Yes. And our problem is that the process we are choosing to drive down unemployment is forcing certain people out of work; and we want to examine what kinds of people are being forced out of work, in effect, and why, and see if we can't remedy that; and I understand what you are saying about the purpose of this hearing.

But part of the reason that I said you don't solve this quality problem with one hearing is that sometimes we lose sight of the fact that at least some of our view of what we are about here, is improving the quality of health care—not trying to detract from it.

Dr. **Roper**. If I could just add one other comment, as an outgrowth of your relaying the comments from the Congressional Research Service, I think to the greatest extent possible we need to be focusing on the outcome of health care services. Surely, it is useful to look at process measures and structural measures; but finally, what we are all interested in, I think, is "Do patients get better over time?" And that is what I am interested in focusing this conference on in the fall. How good are the measures that we have? How can we statistically quantify quality? As a commodity we need to be able to measure it so that we are not just giving subjective estimates.

Senator DURENBERGER. Thank you. Senator Baucus?

Senator BAUCUS. Dr. Roper, where do we have to improve in our quality of health care?

Dr. ROPER. Where do we have to improve?

Senator BAUCUS. Where are there some deficiencies? Where are there some soft spots? Where should the improvements be? Are there any?

Dr. ROPER. Sure.

Senator BAUCUS. What are they?

Dr. ROPER. I am hearing a concern in general expressed about the care that beneficiaries are receiving after hospitalization, and that is one of the——

Senator BAUCUS. I am sorry. Could you speak up?

Dr. ROPER. The immediate posthospital period, I think, is a concern that has been raised that on which we are focusing attention.

Senator BAUCUS. By that, do you mean premature discharges?

Dr. ROPER. Well, the term "premature" indicates that it is inappropriately early. I think certainly we are having earlier discharge, and the concern is over the care that patients are receiving after hospital discharge.

Senator BAUCUS. So, perhaps the postdischarge care is not as attentive or the quality is not as good as it perhaps should be?

Dr. ROPER. That could be. Yes, sir.

Senator BAUCUS. If that is the case, what do you think we should do about that?

Dr. ROPER. In my statement, I talk about what I think is the longer term answer, and that is providing a seamless system of continuum of care—prehospital, hospital, posthospital—under a capitated framework. That is the answer.

Senator BAUCUS. Now, does HCFA or HHS have a recommendation that fulfills that?

Dr. ROPER. Yes, sir.

Senator BAUCUS. I am sorry; I probably missed that. What is it?

Dr. ROPER. We are implementing, through the use of the TEFRA HMO/CMP option, the use of capitated plans, plus we have a bill before the Congress that Senator Durenberger introduced that would greatly expand that alternative.

Senator BAUCUS. Yes. We talked about this earlier.

Dr. ROPER. I hope we continue to talk about it.

Senator BAUCUS. About a month ago. And I am all for new ideas, but I am not sure that this is going to work out too well in some rural areas, frankly.

Dr. ROPER. As I mentioned in my hearing, Senator, there are many different kinds of capitated health plans. While it may be true that there are not traditional closed panel HMO's proliferating in rural areas, there are other kinds of HMO's, typically individual practice arrangements and others being started and growing in rural areas now.

Senator BAUCUS. Where else can we work to improve the quality of health care? What about PRO's? You yourself said you didn't renew the contract in several cases because certain organizations were not doing their job. What can you suggest that Congress do or that HCFA do to improve the quality of PRO's?

Dr. ROPER. What we are doing right now is changing the scope of work for the second round of the PROs' existence. They have been around about 2 years now, and we are focusing relatively less attention on utilization questions and putting more of the scope of work attention on quality issues: readmissions within 15 days; applying a generic quality screen to all cases that are reviewed; and instead of screening a number of patients across all hospitals, we are focusing most of our attention on hospitals with problems and doctors that are having quality problems.

Senator BAUCUS. Could you tell me a bit, too, about your patient rights notice?

Dr. ROPER. Sure.

Senator BAUCUS. As I understand it, it gives a letter to patients informing them of their rights; and I am just curious as to how well that is working and how well that has been received by patients, physicians, and hospitals.

Dr. ROPER. In general, we are extending our efforts to make beneficiaries aware of their coverage, their benefits, and their rights to make sure that they are adequately informed. We have just redone the Medicare handbook. We have just sent a notice to all the intermediaries for them to pass on a letter to Medicare enrollees. We want to make sure that they are aware of what their rights are.

Senator BAUCUS. Are these letters being given to patients?

Dr. ROPER. Yes, sir.

Senator BAUCUS. I have one that is dated May 12, 1985, a message from Medicare, and it lists certain rights. So, that letter is being distributed?

Dr. ROPER. That letter is, but some more recent ones are as well.

Senator BAUCUS. All right. And again, what is the reception?

Dr. ROPER. The reception by beneficiaries?

Senator BAUCUS. Yes. What is the impact of this? Has it been helpful or not?

Dr. ROPER. It has stimulated a much better informed beneficiary population, and I think they are asking questions as they should.

Senator BAUCUS. So, it is working?

Dr. ROPER. Yes, sir.

Senator BAUCUS. All right. As I understand it, the recommendation for Medicare payment increases to hospitals is one-half of 1 percent for next year. Is that correct?

Dr. ROPER. Yes, sir.

Senator BAUCUS. Did the administration earlier recommend a higher percentage?

Dr. ROPER. In the February budget of the President, there was a 2-percent placeholder for the update factor.

Senator BAUCUS. And that has been reduced from the 2 percent—that is, the recommendation has been reduced from 2 percent—to one-half of 1 percent?

Dr. ROPER. The regulation published today has a one-half of 1-percent increase.

Senator BAUCUS. What is that going to do to small rural hospitals, already operating in the red?

Dr. ROPER. I think the major reason that Secretary Bowen and I went with the one-half of 1 percent is that we felt that it is what was needed to ensure quality in the system, both rural and urban hospitals.

Senator BAUCUS. All right. Mr. Chairman, if I might, I would like to ask just one question? Do you know——

Senator DURENBERGER. You can follow up on that one, Max. [Laughter.]

Senator BAUCUS. Do you know what the Prospective Payment Reimbursement Commission's reaction is to that administration's change in hospital reimbursement?

Dr. ROPER. You mean what is their response to the one-half of 1 percent?

Senator BAUCUS. Yes.

Dr. ROPER. They will be rendering a formal response later this month to the whole proposed regulation. I talked to Stu Altman, the chairman of the commission, and to Don Young, the staff director, and I think they are going to be examining our reasons for going to one-half of 1 percent. They haven't given a formal response yet.

Senator BAUCUS. Do you know what their informal reaction is?

Dr. ROPER. I think they are anxious to look at our numbers. [Laughter.]

Dr. ROPER. This is not a number pulled out of the air. The technical justification was there to go below zero, and we chose to go higher because we thought it was needed for ensuring quality of the system.

Senator BAUCUS. Are you saying that they think the payment should be below zero?

Dr. ROPER. Am I saying that the commission does?

Senator BAUCUS. Yes.

Dr. ROPER. No, sir.

Senator BAUCUS. Well, I think you have answered the question, frankly. I must just tell you—and I don't know that you know this—but if you do go to rural America—and by rural America, I mean not only eastern rural America, I mean western rural America—there are vast distances in the West, very vast. And it is incredible to me—well, it is not incredible—how important smaller hospitals are to people who live in those communities, and there are many of them in the country.

In many cases, they are the largest employer or the second largest employer. You know, they are the soul, if you will, of the community because, when small rural hospitals go, the communities go. Physicians obviously can't practice there, and people leave. And that is particularly troublesome today because of the problems facing agriculture in America.

Rural America is already suffering, and I just strongly advise you, when you look at the quality of health care, to also specifically focus on the quality of rural health care because there is a major, major difference between the quality of rural health care and the problem of the quality of health care generally in the country. You yourself said a little earlier that you can't establish national norms. They can't be too rigid in applying the same standards nationwide. I agree with you. I fully agree with that.

Dr. **Roper**. Sure.

Senator **Baucus**. Because I particularly see it in rural America. If you want to have a part of helping that part of the country, then you have to pay specific attention to that part of the country and specific attention to the quality of health care in rural America.

It is not an issue that I am going to let up on, and I don't think that Senator Durenberger is going to let up on.

Dr. **Roper**. I don't expect you to.

Senator **Baucus**. And the sooner the administration faces up to it to find a solution, the better off we are all going to be.

Dr. **Roper**. Let me just respond to that. I know you all held a hearing May 9, and I didn't get confirmed in time to visit with you on that, but I know we will be discussing the issue of rural hospitals and rural health care over the future. There is, in the statute, a different payment rate for rural hospitals and urban hospitals.

Now, if there is a general concern about low payment rates to rural hospitals, it basically arises because of that differential. There are some points in the statute that attempt to address rural hospitals: sole-community providers, rural referral centers, and swing-beds, et cetera. We have been over that before. My concern is that we not say quality is a problem, therefore, the answer to it is a uniform add-on to all hospitals or all rural hospitals because that will solve the problem of quality.

I think there is very scant evidence, if any, that simply more money across the system is going to improve the quality of care. In fact, in 1984, the first year of PPS, hospitals maximized profits as they legitimately should have and shortened lengths of stay. Adding more money on the top will not cause them to broaden their length of stay. I think the issue that this hearing in particular is focusing on is what happens after people are in the hospital, not in-hospital stays.

Quality is good while people are in the hospital.

Senator **Baucus**. When did you say your committee to develop standards is going to report back to you? At the beginning of your statement, you said you asked some group——

Dr. **Roper**. We are going to have a conference this fall on the issue of measuring quality.

Senator **Baucus**. Now, when do you think you will develop standards that will measure quality?

Dr. **Roper**. There is some research available now. When that can be refined, I think is up to the academic researchers.

Senator **Baucus**. Do you have a timetable?

Dr. **Roper**. As soon as possible.

Senator **Baucus**. But do you have a date, like Christmas?

Dr. **Roper**. I think it is a question of trying to improve where we are at every point——

Senator Baucus. I asked the question because nobody really knows what the standards are or should be. To some degree, we are all talking about fluff and air. I think the more we in the administration have developed certain standards, and the more that we in the Congress and, to a large degree, the physicians, the hospitals, and the patients in the country agree with those standards, then we have a better idea and know what we are talking about. Otherwise, we have less of an idea of what we are talking about.

Dr. Roper. Let me try to amplify on a point. I am not saying we need better standards. I am saying we need better measures of the outcomes, better measures of quality; and to that end, we need to look at how sick patients are when they enter the system and how sick they are when they come out, and how much time has elapsed. The rate of improvement over time is the best measure we have of quality.

It is not a very good one, and that is why I want to have this conference and focus our research efforts on measuring quality.

Senator Baucus. All right. Thank you.

Senator Durenberger. Ladies and gentlemen, first, I want to correct an error I made. Jean LeMessurier, who is on our staff, did that excellent paper I quoted earlier. I am used to seeing CRS reports in the front, but Jean has been on the staff now for a few months. She produced it. It is terrific. I recommend it to all of you. I don't know how many copies we have, but I am really proud of this little staff. There are only three people working on this on the subcommittee staff, and in the two talents [laughter].

Janet and Jean, and Ed is their inspiration. Where is he now? Did you get rid of him? But we have fewer people on the subcommittee staff than there are lobbyists just in the front row here today. [Laughter.]

And we have two on the minority side, and we are very proud of those people. One? Is that it? [Laughter.]

Packwood is a bigger cheapskate than Dole. [Laughter.]

Bill, on the 2 percent, or 1 half of one percent issue that Max raised with you, just maybe by way of an observation on your thesis, I understand the thesis. And the thesis is that the solution to the problem is not to spread more all the way across the board. And I can really understand that when I see the inspector general is now telling us that the hospitals made $5 billion in profits, or something like that, last year off the DRG system.

Dr. Roper. That was 1984 data.

Senator Durenberger. Yes. 1984 data. I understand he is not able to be here today to defend his $5 billion profit allegations.

But I can see where you have something like that, on the one hand, and on the other hand, you have the theory that you can't solve the problem just with money—and I sure agree with that theory—that we lose sight of what Max is saying, which is a good example—and that was at a hearing that you couldn't be at because you weren't confirmed.

The head of the PRO from his State—a doctor whose name I should remember because he has been at this since the mid-1970's with a PSRO—he came with a map of the United States of America, and he took the Montana-Wyoming off the map, and he moved it over to the east coast where it went from Chicago to the coast above Washington someplace—New York, I don't know where—and all the way down to the North Carolina-South Carolina border. And when you and I think about rural, you know, we are thinking about real little towns and Hill-Burton hospitals and things like that. When he thinks about rural, that is the wide-open spaces; and folks have a long way to go. And not only that, but hospitals are different in the sense that they have traditionally been health delivery systems. Now, whether it is done by horseback or whatever, there are some very unique kinds of outreach, you might call it, activities that are going on.

That is only by way of saying—and I am sure Idaho is the same way——

Dr. ROPER. I have heard from Senator Symms about that.

Senator DURENBERGER. But that is only to say that the question is whether you begin to address rural problems by continuing the modifications of the payment system as among various kinds of health delivery systems or you begin by chopping everybody down to one-half of 1 percent. And I think where you and I differ is that I would start by trying to modify the distinctions between various kinds of rural hospitals and urban hospitals and so forth, rather than starting with one-half of 1 percent and then later on coming to the modifications because we do, all of us, have hospitals that are terminally ill but not because of the reimbursement system.

Everybody blames the reimbursement system for that. That isn't true. It is not because of the reimbursement system. It is because of the change in the delivery of health care. It is because high quality medicine means we are going to the big town for the big operation and that sort of thing. But there are a whole lot of other things out there that those places have to do or they don't get done, and you don't have any quality because you don't even have any access.

So, if we disagree, and we will disagree on this issue of the 2-percent increase versus the one-half of 1 percent, it is because there are a lot of hospitals out there that are going to be in great pain if they don't get adequate reimbursement—and we know at the same time that a lot of teaching hospitals are going to get rich unjustly. We all know that, so you and us and your very capable staff need to be working very hard—and maybe we can even do something this year—on modifying that rural side of that rural/urban split, maybe putting greater attention on the definition of regional referral centers or something like that.

And I think that we all know that, when you put in definitions of sole-community provider or regional referral center, then you are going to have to meet this criteria and that criteria.

Dr. ROPER. Sure.

Senator DURENBERGER. Maybe we ought to forget about some of those really nitty-gritty little criteria and come up with something that reflects reality.

Dr. ROPER. One of the points you made, our regulation as published today will propose lowering the threshold of the number of admissions to become qualified as a rural referral center. So, presumably, more hospitals will be able to qualify under that regulation.

You make some very good points, and I appreciate your guidance. In general, about the one-half of 1 percent figure, I would just say we published a notice of proposed rulemaking. We have invited comment in a formal way, and I can assure you we have gotten some comments already; and we will look forward to working with you over the summer.

Senator **Durenberger**. I am going to submit some questions in writing because of the shortness of the time; but we need to get at the heart of the PRO issue, I think.

Dr. **Roper**. Yes, sir.

Senator **Durenberger**. It has been raised by a number of the opening statements by some of our colleagues; and you have changed your statement on this from the first time I read your statement. I just want to read you your first statement—and I am not trying to catch you in anything here, but it is the one I remember.

Dr. **Roper**. All right.

Senator **Durenberger**. You go through, in that statement, the pressure on PRO requirements. We like the PRO generally and we have been adding a lot of things we would like them to do, including the latest, new responsibilities under our COBRA.

You say, "These questions are underscored—the questions being, can they handle all this work?—by the fact that three PRO's were terminated during the initial contract period, and 16 of the 31 PRO's that have been evaluated were not automatically renewed for the 1986-88 contract period because of their inability to meet performance standards."

Now, this is the quote that we all need to come to grips with: "We do not yet have a stable core of organizations to perform the review functions currently required of PRO's."

It appears to have been your judgment—and I don't know if it is repeated in your revised statement—so, I will just ask you if it is your judgment——

"We do not yet have a stable core of organizations to perform the review functions currently required of PRO's." Now, if that is true, then before we start loading other responsibilities, we have to think whether or not it is appropriate to do that, or whether we should wait.

Obviously, I read the authority of the PRO's—since I wrote it—to be rather broad; and I don't see that you all are giving them all the things to do that we authorized. So, you must have some very good reasons for not pushing them too far too quickly. Now, we would like them to be looking at this continuum of care. We would like to push them into part B and into outpatient surgery and the whole outpatient department. We would like them to take on a variety of those sorts of things. But at least when your first statement was prepared, it was your judgment that they couldn't do that.

And this is apart from George's question, as to whether or not a Rhode Island manager can come up and work with Maine doctors. I happen to think maybe they can. I mean, if they are good managers——

Dr. **Roper**. They use Maine doctors——

Senator **Durenberger**. But your point still is there has got to be some organizational ability, and you have to be able to deliver a rather significant service. Let me stop right there and ask you to——

Dr. ROPER. You asked if that was my judgment. It is my judgment, Senator. We have gone through a very quick startup period, the first 2 years of PRO's. We are now switching the focus largely from utilization to quality. You all are asking us to take on some new duties as a result of COBRA, and I think your additional question is: What about giving some more duties? My judgment is we would like to stabilize the system before we add more things.

Senator DURENBERGER. And in my questions, I suppose what I am going to be asking you is how do you come to that judgment? I have known Phil since I have been around here, you know, and he is a smart guy; but I wonder on what basis you all are coming to those judgments. If you set up realistic goals and objectives for these people to perform 2 years ago and they haven't performed, then I can understand it. If there was some lack of realism in what you asked them to do, if they weren't accompanied by adequate information going out to a lot of the customers, do you really think you are on safe ground in saying 16 out of these 31 organizations demonstrate some substantial shortcomings in their organizational ability to go and do the job?

Maybe they didn't do this or do that or do that, but does that also mean they lack the organizational ability to do this job?

Dr. ROPER. Some of the ones that were not renewed were not renewed because they didn't document what they had done, and they were not able to prove to us that they had done what they said they were going to do. Those, we are putting up for competition, but we expect the existing PRO in many cases to get the contract and to continue to operate as the PRO for that area. It is, in many respects, therefore, a question of documentation, not of operation.

But my general assertion is, while we are comfortable in many areas, in some we are not; and we want to stabilize the system before we begin instituting further change.

Senator DURENBERGER. Steve Symms?

Senator SYMMS. Thank you very much, Mr. Chairman and Dr. Roper; and I apologize that I wasn't here for your opening statement. As you know, I have worked with you, and I was disappointed that we were not able to get a demonstration project, so to speak, or an example in Idaho.

Is it not true that if the rest of the Nation met the standards that we do in Idaho that we would save about $12 billion in Medicare payments?

Dr. ROPER. That is the figure that you quoted to me in your office, sir. I think it would be substantial. Whether it is $12 billion or not, I haven't run the numbers. But you are right. Health care services are used at a lower rate in Idaho.

Senator SYMMS. The concern that I have is that, with meeting this standard, there is a lot of consternation in Idaho of the intermediary group that did not come up with enough savings because they were already at a standard that was way above the national average, to keep the position; and so, they lost out and didn't even rebid because they felt so chagrined about it. Do you have any hope for States that have done a good job? What is their reward supposed to be?

Dr. ROPER. There are two issues, Senator. One is the level of utilization of health care services, and they are very low in Idaho. If the nation would follow Idaho's example, we would save a bunch of money.

The other question, though, is whether the bills that are being paid in Idaho or anywhere else are being paid appropriately and the function that we disagreed with the intermediary about in Idaho was that they did not intensively enough monitor the bill paying process. But you are right; they chose not to reapply to be the intermediary.

My staff has met with your staff about the idea of a demonstration in Idaho, and we are working on that still.

Senator SYMMS. So, you think that is still a possibility?

Dr. ROPER. A possibility? Yes, sir.

Senator SYMMS. How about the PRO in Idaho?

Dr. ROPER. Since the intermediary was the PRO, there will be another PRO since Blue Cross has dropped out.

Senator SYMMS. And where will they come from?

Mr. NATHANSON. We are conducting an open competition, and we do have a bid. We really can't discuss it because we are in negotiations right now.

Senator SYMMS. I just think we need to take advantage of the opportunity—this is more of a statement than a question—but I just want to encourage you to try to use the same standards for the rest of the country. When they get up to where they are doing as well as we are then I wouldn't feel bad about having the intermediary changed or whatever to meet the standards. But it appears to me that we are doing a very good job in our State. And I have felt that the medical profession in the State have delivered services and have been very sensitive to those costs. And somehow in the giant bureaucracy of HCFA and so forth, they feel very chagrined that they got run over, and I just want to say that.

Then, on the other question, is there anything in your plans to change the language in the letters that go to patients who are on Medicare who go to the doctor, get a doctor's call at the office, and then they get this letter that tells them that the doctor overcharged them? I think the Medicare will pay like $12.00 and the doctor's call may be $25 or $30 or something. Do you have any plans to change that?

Dr. ROPER. I will sure look into that, sir. I am not aware that we are telling people that a doctor is overcharging.

Senator SYMMS. It is the tone of the letter; it is the impression. And in my opinion, it drives a wedge between the doctor and the patient, and that is bad for medical care in the United States for the long run.

Dr. ROPER. Sure it is.

Senator SYMMS. We need to have a good personal relationship wherever possible between the physician and the patient. And it concerns me that when the Government writes the letter out there, they give the impression in the letter that somehow the physician has overcharged the patient, which is not the case. We simply don't have enough money to pay the entire bill, and the patient is being asked to pay a portion of it. But I think that is an area where just the tone of the letters could help on this problem and help for the future. I would sure hope that, as a physician yourself, you would be very sensitive to that and get your staff to show you all those letters.

Dr. **Roper**. I will.

Senator **Symms**. I have patients who are constituents of mine who grab me at the local fair or somewhere and say that they are really upset because these doctors are overcharging. Well, they are not overcharging. They are charging what they have to charge to keep their nurse in the office and do the various tests and so forth. There is a market there, too, and they are in competition with their other physicians.

I just hope we would be careful about that, to not make the situation any less personal than it is already getting to be.

Dr. **Roper**. I will take a look at that.

Senator **Symms**. Thank you. Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you, Steve, very much.

John Heinz, we introduced you about an hour and 15 minutes ago as the person who is really responsible for our coming together here today and for your demonstrated concern individually as chairman of the Committee on Aging, in just watching this prospective process for the 3 years it has been in effect. So, we are glad that you were able to get away from the President long enough to come by.

Senator **Heinz**. Mr. Chairman, first, I want to commend you for holding this hearing. And you are quite right, this has been a concern of the Committee on Aging for quite some time; and you are also correct that the House and Senate Republican leadership were down at the White House, and we just adjourned.

I regret that Dr. Roper's testimony was not available until very late last night. Frankly, I hope, Mr. Chairman, that in the future, our witnesses will submit their testimony in advance, according to the rules as they are supposed to do.

As a result, I am not particularly comfortable with scanning all of Dr. Roper's testimony at sight, and then asking copious questions. Let me just ask this. If it would be agreeable with the committee, I would like to pose a few questions to Dr. Roper, and then at the appropriate time make a few brief remarks, by way of testimony, and take you up on your scheduling of me as a witness.

Senator **Durenberger**. All right.

Senator **Heinz**. Dr. Roper, it is nice to see you again.

Dr. **Roper**. Good morning, sir.

Senator **Heinz**. Is there a reason that you can't get your testimony in earlier? [Laughter.]

Dr. **Roper**. I take your admonition to heart, sir. It will not be late next time.

Senator **Heinz**. Why couldn't you get it in?

Dr. **Roper**. You may be aware, Senator, that we have been doing some other things—publishing a regulation, for example. And it was tardy. It will be on time next time.

Senator **Heinz**. As you know, I have been in touch with you and the Secretary regarding the data base for assessing quality of care under PPS and the need for additional data for that purpose.

Dr. **Roper**. Yes, sir.

Senator **Heinz**. And also to evaluate the various successes of the prospective payment system and its deficiencies or shortcomings.

Now, just let me ask you a general question. Do you believe we have any quality shortcomings now that we didn't have 4 years ago? Are we better off today in terms of quality than we were 4 years ago?

Dr. ROPER. Yes, sir; we are very much better off.

Senator HEINZ. In quality?

Dr. ROPER. Yes, sir.

Senator HEINZ. Have you got any information to prove that?

Dr. ROPER. In general, the morbidity, mortality statistics in the Medicare population continue to improve. Things are better. As I indicated before you came in, there is some concern that has been focused, largely through your efforts, on the immediate posthospital period; and we are putting in place data gathering efforts to focus attention on that.

Senator HEINZ. Are people being discharged sicker and quicker today than they were 4 years ago?

Dr. ROPER. The length of stay has shortened and earlier discharge is happening. Yes, sir; that is the incentive built into the prospective payment system.

Senator HEINZ. So, the answer to that question is "Yes"?

Dr. ROPER. I prefer not to use "sicker and quicker." I understand that many people do, but some people are being discharged more severely ill than they used to be. Nobody should be discharged inappropriately, and that is what we are trying to focus our attention on.

Senator HEINZ. I think it is legitimate to make a distinction between inappropriate discharges and the question or issue of whether people are, in fact, being discharged sicker and quicker. I think most of the statistics strongly support the proposition that they are, and it is not necessarily bad. Under certain circumstances, it can be.

So, your answer is now that I have qualified it——

Dr. ROPER. Sure.

Senator HEINZ. And rephrased the question—the answer is yes?

Dr. ROPER. Yes.

Senator HEINZ. It shouldn't be this hard.

Dr. ROPER. I agree.

Senator HEINZ. Do you believe that there is an increase in the incidence of inappropriate discharges under PPS?

Dr. ROPER. No, sir.

Senator HEINZ. Have you got the statistics to back that up?

Dr. ROPER. We are aware of between 3,000 and 4,000 cases a year that appear to be inappropriate by early discharges. That is not an increase over previous years.

Senator HEINZ. The 3,000 to 4,000 is or is not based on a sample?

Dr. ROPER. I think it is based on a sample.

Senator HEINZ. And what information are you comparing that to, say, pre-1983?

Dr. ROPER. Comparing it to a general estimation; comments of thoughtful observers on the system.

Senator HEINZ. With all due respect, Dr. Roper, what you are saying is that we have this sample and it says that 4,000 people that we know about were inappropriately discharged, and we guess that that is no better or worse than before. But the fact is you have no idea what the situation was before. Isn't that right?

Dr. ROPER. As I mentioned before you came in, sir, one of the major efforts that we are going to put in place is measuring quality of care now and in the future. Data in the past are either nonexistent or are not good quality.

Senator HEINZ. Why did HCFA decide to limit the MADRS data base from 1982 forward?

Dr. ROPER. MADRS, Medicare Automated Data Retrieval System, is a very important and a very complicated effort. And since you are familiar with it, you will know that it has taken us longer than we had anticipated to get it in place. The judgment to go with 1982 and forward is simply a desire to get the system in place quickly now and get on with collecting data for the future.

Senator HEINZ. If you had historical data, wouldn't that help answer definitively quality of care and health care delivery questions such as those that I have posed to you?

Dr. ROPER. More data would be more useful. Yes, sir.

Senator HEINZ. What is the basis for HCFA's decision to have individual PRO's during the next contract cycle prepare their own software for automated monthly and quarterly review activity reporting to HCFA, rather than having a systemwide software package which can be added to or subtracted from? Why did you opt to have each PRO develop its own software? Am I correct on that?

Dr. ROPER. For a simple reason: They have different hardware, and a single set of software would not run on all the hardware units. We have put in place, though, standards so that the data collected will be able to be analyzed nationwide. It is not a problem of a lack of comparability; it is rather that the hardware is different, so it takes different software.

We will be able to do what you have in mind with the system we have in place.

Senator HEINZ. Are there really that many different kinds of hardware?

Dr. ROPER. Yes, sir. Different computers, different manufacturers, different—Yes, sir.

Senator HEINZ. And it is still more efficient, rather than writing a master software program and having that translated into the language of the various hardware manufacturers? Ultimately, it means translating it into the machine language, anyway. You are saying that it is still better to make everybody reinvent the wheel?

Dr. ROPER. No, I am not saying that at all. I am saying what we are after is a nationwide system of intelligible data that can be analyzed. Our judgment is that a single software application is not the best end to that.

Senator HEINZ. On May 12, Senator Durenberger, Senator Chafee, and myself sent Dr. Bowen a letter detailing, with quite a bit of specificity, the information issues that we believe need to be addressed with respect to the prospective payment system by HHS. Has that letter been received?

Dr. ROPER. Yes, sir.

Senator HEINZ. What are your plans to respond to that letter?

Dr. ROPER. We are developing responses to the five or six specific questions that you had in place, and we will be responding shortly.

Senator **Heinz**. By the end of the month?

Dr. **Roper**. Yes, sir. I have oral responses to those now, if you would like to go over them.

Senator **Heinz**. I don't think we need to take the committee's time, but I would welcome those responses for the record.

Dr. **Roper**. Sure.

Senator **Heinz**. I would ask unanimous consent, Mr. Chairman, that we might put into the record our letter of May 12 and Dr. Roper's answers to follow in the record immediately thereafter.

Senator **Durenberger**. Without objection, it is so ordered.

[The prepared letter and the response thereto follow:]

United States Senate
WASHINGTON, D.C. 20510

May 12, 1986

The Honorable Otis Bowen, M.D.
Secretary, Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Bowen:

We are concerned that the Department's research agenda for assessing the effect of the Prospective Payment System (PPS) on the Medicare program and its beneficiaries is insufficient.

The Congress has received a study by the Office of Technology Assessment (OTA), and a preliminary report from the General Accounting Office (GAO), on the impact of Medicare's PPS on hospital and post-hospital care. In addition, the Senate Special Committee on Aging has carried out an intensive investigation of quality of care under PPS. These inquiries have raised numerous questions about the Department's PPS evaluation plans. We believe it is time for a major revision of those evaluation plans so that policymakers will have the information needed to determine the effect of PPS on quality, access to care, Medicare costs, and other aspects of our health care system.

We believe that direct action on your part is necessary in the evaluation arena. We have three primary areas of concern:

(1) Evaluation Plans. The Department did not develop, prior to implementation of PPS, evaluation plans adequate for determining the effect of this major change in the Medicare program. This information gap must be filled. Both OTA and the GAO have identified, for example, the Department's lack of baseline data and appropriate methodologies for measuring changes in beneficiaries' access to care, and in the quality of care they receive.

We were disturbed, therefore, by testimony before the Senate Special Committee on Aging by a former HCFA administrator, who stated that approaches for monitoring and evaluation of the effects of PPS on post-hospital care will be developed only when the expansion of PPS to home health and skilled nursing home care is underway. Given the Department's current difficulties in evaluating the effects of PPS, it appears likely that a decision to delay the development of baseline data and a methodology for measuring PPS effects on post-hospital care will produce damaging uncertainty about the effects of any expansion of PPS to other providers.

(2) **Medicare Administrative Data:** Severe problems with the administration and organization of Medicare data are inhibiting evaluation of the effects of major policy changes on the full range of Medicare services.

Both OTA and GAO have reported that data are available at HCFA which could be used to address the effects of PPS on the use of, and expenditures for, Medicare home health and skilled nursing facility services, and that such research can be done in a timely and relatively inexpensive manner. In addition, both GAO and OTA believe that HCFA's ability to produce evaluative information would be enhanced by completion of the Medicare Automated Data Retrieval Systems (MADRS). We appreciate the time and expense needed to complete such a comprehensive data file; however, the delays involved in this project's completion seem excessive, particularly in comparison to its usefulness.

We are particularly concerned that current plans are to complete this data file from 1982 forward, rather than from 1980 forward. According to GAO, this would seriously limit the amount of pre-TEFRA information available for analysis, thereby limiting the utility of the file for analyses which could help explain the effects of TEFRA and PPS. HCFA should give top priority to improving the state of Medicare data so that important analyses can be done in a timely and efficient manner.

(3) **Structure of the PRO System:** Basic flaws in the structure of the Peer Review Organization (PRO) system are limiting its ability to produce information on the quality of care purchased by Medicare. Review of hospital readmissions, currently the primary mechanism which PROs use for ensuring the quality of inpatient care to Medicare beneficiaries, is inadequate as the primary measure of quality of care.

First, the limitations on the definition of a "readmission," and the type of review employed by the PROs mean that many aspects of care given during the hospital stay are not systematically examined. For example, rates of surgical complications or iatrogenic disease are not routinely monitored. While the new PRO Scope of Work will remedy this problem to some extent, we remain concerned that the resulting data will lack the necessary comparability for national evaluations of quality of care.

Second, PRO review is ineffective in its evaluation of the appropriateness of hospital discharge decisions. Under the current system, for example, a patient who was prematurely discharged and died without returning to the hospital would not be identified. Similarly, while PROs attempt to determine whether certain readmissions may have occurred as the result of a premature discharge, they do not examine the possibility that a patient needed but could not or did not obtain appropriate post-hospital care.

Even if PROs do begin to review various aspects of the process and outcomes of care in post-hospital as well as hospital settings, these organizations do not perform their reviews based on standardized criteria which could be compared and analyzed for national or regional patterns. We are unaware of any systematic effort on HCFA's part to create a usable PRO research data base. HCFA has recently decided, for example, to have each PRO develop its own software for monthly and quarterly reports on review and sanction activity. This decision can only result in a wide variety of formats and possibly even discrepancies in the content of reports to HCFA. The central office of HCFA should develop uniform software to shape the content and format of these vital reports from PROs. Without reliable and uniform national data, we will be forced to make decisions about the national Medicare program based upon noncomparable and non-generalizeable reports from the PROs.

Our goal is the timely development of useful and policy-relevant information on changes in health care services caused by Medicare payment reforms. We believe that the Department should develop a clearly specified evaluation plan, which incorporates the efficient and coordinated use of existing data, to address the full range of Medicare services.

In closing, we would appreciate receiving your specific response to questions that have emerged from the OTA, GAO, Finance Committee and Aging Committee inquiries into the effect of PPS:

1. Why did HCFA decide to limit the MADRS data base to information gathered from 1982 forward?

2. When will MADRS be completed? What previous target completion dates have passed?

3. What is the status of any and all evaluation plans the Department has developed, or is developing, for assessing the

effects of extending PPS to other Medicare financed services (such as home health and skilled nursing facility care)?

4. What is the status of any and all studies the Department has underway or under development to identify the impact of the inpatient hospital PPS upon access to post-hospital services for the Medicaid eligible Medicare population? When are such studies scheduled for completion?

5. What is the basis for HCFA's decision to have the individual PROs, during the next contract cycle, prepare their own software for automated monthly and quarterly review activity reporting to HCFA? Why was the option of a uniform central office software program for these purposes discarded? How will this decision affect the ability of the SuperPRO to evaluate PRO performance?

6. Please provide details on the proposed "after-care study" to which the Department makes reference in its comments on the GAO PPS post-hospital care study.

We look forward to working with you on these issues and stand ready to help in any way we can to achieve an evaluation agenda and work plan for the Department that responds to the concerns we have outlined above. Please feel free to contact either of us regarding this letter, or to have your staff communicate with Beth Fuchs of the Aging Committee staff or Chip Kahn of Senator Durenberger's staff.

Thank you for your time and attention to this matter.

Sincerely,

John Heinz

JOHN HEINZ
Chairman, Special
Committee on Aging

Dave Durenberger

DAVID DURENBERGER
Chairman, Finance Committee
Subcommittee on Health

John H. Chafee

JOHN H. CHAFEE
Chairman, Finance Committee
Subcommittee on Taxation and
Debt Management

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 22 1986

The Honorable John H. Chafee
United States Senate
Washington, D.C. 20510

Dear Senator Chafee:

This is in reponse to your letter of May 12 in which you raise a number of questions about the Department's research agenda for assessing the effect of the prospective payment system (PPS) on the Medicare program and its beneficiaries. In your letter three major areas of concern are outlined. These are: Evaluation Plans, Medicare Administrative Data, and Structure of the Peer Review Organization (PRO) System.

I am enclosing a detailed response to each of these areas, in turn, by clarifying current plans and activities of the Department relevant to your concerns. I apologize for the delay in preparing comments.

Similar responses have been sent to Senator Durenberger and Senator Heinz.

Sincerely,

Otis R. Bowen M.D.
Secretary

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 22 1986

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

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Otis R. Bowen M.D.
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Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 22 1986

The Honorable David Durenberger
United States Senate
Washington, D.C. 20510

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Sincerely,

Otis R. Bowen M.D.
Secretary

Enclosure

Comments on the Department's Research Agenda

(1) Evaluation Plans. In developing its PPS evaluation plan, the Department has expended a great deal of care in defining a comprehensive set of economic, access, and quality issues relating to PPS, and their implications for hospitals, beneficiaries, and other payors. Enclosed is a matrix drawn up by the Health Care Financing Administration (HCFA) summarizing the range of these evaluation issues. This framework provides the basis for designing and implementing specific projects and analyses, on an on-going basis.

Within HCFA, this evaluation plan is coordinated closely with the PRO program as a means of feeding back information and developing improved techniques for monitoring the quality of care. This evaluation strategy is also shared with the Prospective Payment Assessment Commission (PROPAC) and other concerned organizations on a continuing basis.

Most importantly, a Technical Advisory Panel (TAP) has been established representing a wide range of expertise and private sector interests. This panel meets periodically and represents a forum for discussing complex technical issues that invariably accompany a major social change such as PPS. More specifically, this panel provides guidance on interpreting interim results of studies underway and future directions of the PPS evaluation strategy. Based upon these deliberations, specific PPS evaluation projects are defined and implemented on an on-going basis.

Currently, the Department is implementing a wide range of studies to evaluate access and quality of care under PPS. There are seven major studies underway. These studies do rely heavily on the use of baseline data and focus on: (1) examining changes in the process or outcomes of care associated with the implementation of PPS; (2) finding improved measures for monitoring hospital care; (3) examining health status at the time of discharge; and (4) analyzing the appropriateness of post-discharge (aftercare) care services.

Two of the studies are focusing on the effects of PPS on a broad range of hospital utilization and patient care outcome indicators. Among the indicators being studied are: discharge rates, hospital days of care rates, length of stay, population-based mortality rates, post-admission mortality rates, and others. These data are derived primarily from the Medicare Statistical System (MSS), and the Professional Activity Study (PAS) — a privately maintained, clinically oriented, medical record abstract data system. The PAS provides useful data to supplement the MSS including information on surgical lengths of stay, use of intensive care units and coronary care units, physician consultations, and others. Both studies employ a pre-post design.

Results from these studies form the basis of an in-depth analysis covering the impact of PPS on quality and access, focusing on the years before PPS and the first year of PPS. This analysis and extensive results will be presented in the 1985 PPS Report to Congress. The specific quality and access findings will be reported in eight sections entitled:

- Hospital Utilization
- Issues in Evaluating Mortality Rates
- Population Based Mortality
- Post-Admission Mortality
- Hospital Readmissions
- Concentration of Cases Within and Among Hospitals
- Enrollee Liability
- Commission on Professional and Hospital Activities: Hospital Use, Patient Disposition and Severity

Three longer range studies are in progress. These are a detailed analysis of the End Stage Renal Disease population being performed by the Urban Institute and two clinically oriented studies being performed through cooperative agreements with the Rand Corporation. The first of the Rand studies involves a pre-post PPS analysis of clinical treatment patterns for selected diagnoses, based upon a thorough examination of the medical record. The second Rand study concerns the identification of administrative data useful in discovering quality of care problems in individual hospitals, e.g., diagnosis-specific readmission and mortality rates. Results of these studies will be available within the next 2-3 years.

In addition, the Northwest Oregon Health Systems agency is developing a method to measure health status at the time of hospital discharge and to measure changes in discharge health status associated with PPS implementation. The results of this study are expected to prove useful in assessing functional ability and the need for aftercare services. Specific information concerning the Department's efforts at assessing aftercare services is described in more detail in response to your specific questions on this subject.

Moreover, the Office of the Assistant Secretary for Health is performing an analysis of quality related issues aimed at developing a comprehensive research agenda for both the public and private sectors.

(2) Medicare Administrative Data. HCFA maintains numerous data bases for research and demonstration purposes. Extensive use of these data is made in evaluating the effects of PPS on hospital utilization, mortality patterns and other quality and access indicators, as described previously. Moreover, HCFA is currently in the process of creating a data base which links all Part A and Part B records for a sample of Medicare beneficiaries.

A number of research and demonstration projects funded by HCFA affect small numbers of Medicare beneficiaries or small geographic areas. The purpose of the Medicare Automated Data Retrieval System (MADRS), currently under development, is to organize Medicare administrative files so that data can be retrieved quickly and cost effectively for purposes of performing evaluative research into these types of projects and other small area analyses.

The MADRS will be organized into yearly files by date of service and then by State/county code and within county by Medicare beneficiary number. Researchers will be able to retrieve data by county, Medicare beneficiary number, and Medicare provider number (for institutional providers).

While MADRS is an important data base concept, we must emphasize that quality analyses are proceeding independent of the construction of MADRS. We feel that the quality studies described above, based on existing MSS data files, will provide a significant contribution to our understanding of the impact of PPS on Medicare beneficiaries.

More detailed information regarding MADRS is provided below in response to your specific questions.

(3) Structure of the PRO System. It is true that PRO data reporting on quality issues under the first cycle Scope of Work was restricted to readmissions. However, it is not true that readmission review is the only PRO activity related to quality of care. PROs perform extensive review activities as a part of their ongoing functions related to both PPS oversight and quality of care. Quality of care review is a fundamental charge of the PRO function, and this ongoing activity will be better reflected under the second contract cycle by the extensive proposed changes to the data collection system.

The only limitation that we have placed on the definition of a readmission is that the two admissions appear to be related; that is, that there is a possibility of an interrelationship between the two stays. For example, if a patient was admitted for gall bladder surgery and then was readmitted for repair of a broken hip, one could assume that the second stay probably was not an extension of the first stay, i.e., a premature discharge had not occurred.

In the new PRO Scope of Work, we mandate that readmissions within 15 days must be reviewed, thus broadening the span of time between discharge and readmission. We did this to enlarge the number of cases reviewed by the PRO so that we can ascertain if there is any systemic problem with premature discharges and take corrective actions if premature discharges are identified.

Also, in the new Scope of Work, every case under review is to be subjected to generic quality screens. The generic quality screens focus on such things as: adequacy of discharge planning, medical stability at discharge, deaths, nosocomial (i.e., physician-caused or hospital-acquired) infections, unscheduled returns to the operating room, and traumas suffered in the hospital. Also, short stay cases will be tracked and reported separately to determine the magnitude of quality problems in these cases.

In addition to the generic screen review, each case reviewed will undergo discharge review. The discharge review will look at such things as stability of the patient at the time of discharge and adequacy of discharge planning. Thus, under the new contract cycle, PROs will focus more directly on the evaluation of the appropriateness of hospital discharge decisions.

Even though PROs will not review every Medicare admission, we feel that our review percentage (25 percent on the average) is large enough to identify any systemic problems and require hospitals and practitioners to take corrective action.

By statute, the PROs are to apply professionally developed criteria to each case under review. These criteria are based upon typical patterns of practice within one geographic area served by the organization (i.e., the State), taking into consideration national norms where appropriate. Thus, the statute requires the PRO to take into account geographic variation when reviewing the care received by Medicare beneficiaries.

Although there are inherent regional differences in PRO review which make some inter-regional comparisons impossible, HCFA maintains a standardized analytical data base comprising PRO reported findings. This analytical data base will be expanded dramatically both in scope and technical capabilities under the second contract cycle proposed reporting requirements.

In addition to the above concerns, you have posed specific questions that have emerged from the General Accounting Office (GAO), Office of Technology Assessment, Finance Committee and Aging Committee inquiries into the effect of PPS. These questions are addressed below:

1. Why did HCFA decide to limit the MADRS data base to information gathered from 1982 forward?

The original plan was to create MADRS files for each year beginning in 1980. During the development of MADRS, it appeared advisable to preliminarily process data for the period of January 1980 to July 1983 (Pre-PPS Format). During the preliminary processing of the data it was possible to extract data for existing research and demonstration studies. This was done and 16 projects were provided with data. Having satisfied all of the known requests for 1980 and 1981 data, it seemed appropriate to begin the creation of MADRS files with 1982 and wait to see if additional data requests for 1980 and 1981 materialized before spending the resources to create MADRS files for these years. It was also felt that it was important to have available now the more current years of MADRS data.

2. When will MADRS be completed? What previous target completion dates have passed?

HCFA began the development of MADRS in August 1983 with the award of a contract to develop the MADRS program and create MADRS files for the years 1980 to 1982. The due date for completion of this project was March 1984. The contractor performance on this project was very poor. Despite repeated efforts to remedy this situation, the contractor was only able to partially complete work on the MADRS programs by January 1985 before defaulting. It was necessary to procure another contractor to test and rectify the MADRS programs and create MADRS files. A purchase order was awarded in June 1985 to carry out the testing of the MADRS programs. This procurement produced a report on schedule in March 1986 on the test and changes required in the programs. Another purchase order is about to be awarded to fix the programs and produce a 1982 MADRS file. The schedule for completion of these tasks is September 1986. The current schedule calls for proceeding to create 1983 files and MADRS files as soon as possible thereafter.

3. What is the status of any and all evaluation plans the Department has developed, or is developing, for assessing the effects of extending PPS to other Medicare financed services (such as home health and skilled nursing facility (SNF) care)?

HCFA is sponsoring a number of demonstrations related to this issue. With respect to nursing home care, the State of Texas is developing a case-mix system for its Medicaid program, and New York and Maine have recently implemented systems which will be studied by HCFA. The New York system is based on resource utilization groups (RUGs). There is also a Medicare project to develop RUGs for Medicare nursing home patients, and another to design a demonstration extending the hospital prospective payment system to include post-hospital care provided to Medicare patients by SNF and home health agencies (HHAs). The New York, Texas, and Medicare/RUGs projects each have primary data, including patient assessments and actual staff time, collected in at least 50 facilities. The patient assessments were carefully designed to permit comparisons across studies. HCFA is also continuing to analyze various State patient-related reimbursement systems, including West Virginia, Ohio, Maryland, Colorado, Illinois and Minnesota.

Finally, HCFA has been working with the Rand Corporation as part of its Health Research Policy Center Cooperative Agreement to study the feasibility of developing a combined hospital and post-hospital prospective payment system. The purpose of this effort is to explore the feasibility of doing demonstrations in this area and to develop alternative payment methods to be tested.

4. What is the status of any and all studies the Department has underway or under development to identify the impact of the inpatient hospital PPS upon access to post-hospital services from the Medicaid-eligible Medicare population? When are such studies scheduled for completion?

The aftercare study, which is discussed below, will include the capability of oversampling vulnerable population groups, such as the oldest-old or dual eligibles, to study, in detail, the adequacy of post-hospital care for these beneficiaries.

In addition, we awarded last year a cooperative agreement with Georgetown University, entitled "PPS and Post Hospital Care: Use, Cost, and Market Changes." The aim of this research study is to determine how much hospital prospective payment shifts care to nursing homes and home health providers and to analyze the impact of that shift on total costs to Medicare, pre- and post-PPS, of an illness involving hospitalization; and changes in SNF characteristics—connections with hospitals, intensity of service, and the likely increased use by Medicare beneficiaries in the future. Final results of this study are expected by March 29, 1988.

5. What is the basis for HCFA's decision to have the individual PROs, during the next contract cycle, prepare their own software for automated monthly and quarterly review activity reporting to HCFA? Why was the option of a uniform central office software program for these purposes discarded? How will this decision affect the ability of the Super PRO to evaluate PRO performance?

It is true that PROs are required to develop their own reporting software based on detailed HCFA specifications. All reporting is uniform and defined in detail to ensure consistent and comparable data base development. Development of generic software for use in PRO systems is technically and conceptually undesirable since the hardware is not standardized. Software cannot be developed on an efficient basis which will operate on the wide range of hardware and operating systems which are being used by PROs. Thus, we have chosen to allow the PROs to seek the most efficient means of developing reporting summary software which is consistent with their operating environment. This may include either inhouse programming or subcontracted cooperative programming for PROs with compatible systems.

We believe we have provided for all systems activity which can efficiently be handled on a centralized basis from a uniform PRO reporting base. Our report editing and transmittal specifications, centralized data base development and data access design represent that full extent of activity. We are prepared to fully test data from all systems which PROs may develop to ensure compatibility with the HCFA input edits and data base standards.

6. Please provide details on the proposed "after-care study" to which the Department makes reference in its comments on the GAO PPS post-hospital care study.

This study, which is being jointly sponsored by HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) will address Medicare patients' needs and access to post-acute aftercare services. The basic approach of this study will involve developing a reliable method of: (a) assessing Medicare patients' health status and needs for post-discharge services at the time of discharge, and (b) surveying the adequacy of post-discharge care in relation to patients' health care needs. As part of the post-discharge survey, patient and family burden (including financial burden) will also be assessed.

The aftercare study is being designed to directly address concerns that have been raised regarding availability and access to aftercare services once Medicare beneficiaries have been discharged from the hospital. Medicare patients especially vulnerable to inadequate post-hospital care may be those who have undergone immobilizing procedures such as hip surgery or patients who need intravenous medications. These patients, who may require either informal support services or formal sub-acute services, represent an important focus of the study. Still other patients with continuing long-term care needs will also be assessed. Recently, HCFA and ASPE held a pre-contract conference with expert clinicians to gain their perspective on the clinical issues of this study. The results of that meeting and several technical issues of the study were presented to the PPS-TAP on April 30 for advice from these private-sector experts.

A pilot study to test these methods is currently being designed and is expected to be completed by May 1987. A detailed study plan for the pilot study is currently being developed which should be completed in the very near future. This plan will address the technical details of developing sampling strategies, measurement scales, survey procedures, and data analysis. The instrument being developed by Northwest Oregon Health Systems (described earlier) will be considered as a possible method for measuring health status at discharge. We would be happy to share the details of the pilot study plan with you as soon as it becomes available. Following the pilot study, a national assessment is planned.

Based upon our efforts, to date, HCFA will be sponsoring a conference to be held this coming fall to discuss methodological approaches for measuring quality of care. I feel confident that, through the efforts described here, the Department will be able to provide Congress and the general public with reliable analyses of PPS impacts on access and quality of care. I would be happy to meet with you to discuss our plans and PPS evaluation efforts, and to hear from you any suggestions for improving or supplementing our current strategy.

Prospective Payment System (PPS) Study Issue Matrix

Impact Measures	Program Implementation	Expected Impact on Providers, Payers, and Beneficiaries				Cost Control	
Program Status:	[illegible]	Hospitals	Medicare Beneficiaries	Other Providers of Health Care	Other Payers for Inpatient Hospital Services	Hospital Expenditures	Total Program Expenditures
Economic Impact: • Anticipated Benefits—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
• Unintended Consequences—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Impact on Quality of Care: • Anticipated Benefits—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
• Unintended Consequences—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Impact on Access to Care: • Anticipated Benefits—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
• Unintended Consequences—		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Senator **Heinz**. Mr. Chairman, there is obviously a lot that we could cover with Dr. Roper. I have taken more than my 5 minutes, and I think, in the interest of fairness to the chairman, I should reserve the balance of my exhausted time.

Senator **Durenberger**. John, thank you very much. Bill, from each of us you will be getting additional questions, as all of us have indicated. We appreciate very much your being here.

I guess I would reiterate what John Heinz said about the testimony and only because I know that you are very well intentioned as you enter into this new job and so forth. You did have a draft that you submitted ahead of time, but we are always left a little uneasy like I was here. I had prepared a couple of questions for you based on my reading of your initial testimony. And then, when I got this new one, I can't find the original reference that came to mind.

So, it isn't just a matter of staff work. I guess that is the point that John Heinz is making, too. It isn't just a matter of holding up our staff; at least in the case of several of this committee, we take a personal interest in what you have to say so we can make these hearings as meaningful as possible. So, if you really do follow through on your commitment of meeting the 48-hour deadline, or something like that, then for those on this committee—and I think it is most of the committee—who take a strong interest in this, that would be most helpful.

Dr. **Roper**. I will do that, sir.

Senator **Durenberger**. All right. Thank you very much for your testimony.

We next have a panel consisting of Michael R. Goldwyn, executive director of the Northwest Oregon Health Systems—

Excuse me. Before the panel comes up, we have our honored guest, Hon. John Heinz of the U.S. Senate from the State of Pennsylvania.

I was so impressed by your questions, I thought that was it. [Laughter.]

Senator **Heinz**. Mr. Chairman, I thank you. I think I had better move myself.

Senator **Durenberger**. Please do. Be our guest.

Senator **Heinz**. Mr. Chairman, I find it always teaches humility to appear down here, and I feel for Bill Roper and his new responsibilities. I can imagine how he felt facing more of us than him.

Senator **Durenberger**. Having been on the floor yesterday, presiding when John Glenn came on and did his "here is how we prepare for television act," I am suitably impressed by your navy blue suit and blue shirt. [Laughter.]

Senator **Heinz**. Mr. Chairman, I compromised on the tie. It is only partly red. [Laughter.]

Senator **Heinz**. Mr. Chairman, I want to thank you today not only for holding this hearing, but for permitting me, particularly out of order, to testify. Obviously, we are all concerned about Medicare's prospective payment system, and we want to be sure that the quality of care received by senior citizens is top quality care. It certainly ranks as one of this committee's highest priorities—I know yours.

Indeed, I know that since you are an original cosponsor of the Heinz-Stark bill. As you know, I chair the Special Committee on Aging. We have conducted a very lengthy and intensive investigation on the quality of care under PPS. We are about 3 years into PPS and frankly, notwithstanding Bill Roper's testimony, it is evident that problems with quality as well as access are emerging and that they are problems that demand our immediate attention and response.

I would like to share with you just two examples from the literally thousands of cases of quality abuse that we uncovered during the Aging Committee's 16-month investigation.

Case No. 1 involved an 85-year-old woman who was discharged from a hospital about 12 days after she was admitted because "her Medicare coverage was up." She was, to boot, sent to a substandard nursing home. It was against her doctor's orders and against her family's wishes, and she died there within 14 hours. And to add insult to injury, 2 days later the family received a letter informing them of their rights to appeal the decision to discharge her.

What else have you done for me lately?—I think that is called—or maybe it is to me lately.

The second case involves a 75-year-old woman who was in a car accident in which her car was totaled. Basically, because of the reimbursement guidelines under prospective payment, she was denied admission to the hospital. Then she was sent home, given instructions that she should—with this suspected concussion—wake herself every 4 hours to see if she was awake. Got that?

Senator DURENBERGER. Yes. I am lucky; I have an alarm. [Laughter.]

Senator HEINZ. Keep it; I may need it. And this was even though she lived alone.

What is happening, of course, is that the new prospective payment system provides incentives for skimping dangerously on health care, not just squeezing costs. And the fact that these cases and others like them happen under our new PPS system is, to my mind, unacceptable.

Now, my concerns about problems developing under PPS led you and me and others to introduce S. 2331, the Medicare Quality Protection Act. That was back on April 17. There is good, broad bipartisan support for that bill. I would ask unanimous consent that a list of the sponsors, cosponsors be inserted at this point in the record.

Senator DURENBERGER. Without objection, it is so ordered.

[The prepared list follows:]

COSPONSORS

S. 2331 HEINZ (14 COSPONSORS)

Finance Committee: (1) Durenberger; (2) Chafee; (3) Bradley; (4) Moynihan; (5) Matsunaga.

Others: (1) Glenn; (2) Kennedy; (3) Chiles; (4) Bumpers; (5) Rockefeller; (6) Riegle; (7) Dodd; (8) Wilson; (9) Cohen.

H.R. 4638 STARK (29)

Ways and Means: (1) Gradison (R); (2) Jacobs (D); (3) Rangel (D); (4) Donnelly (D); (5) Coyne (D); (6) Pickle (D); (7) Daub (R); (8) Gregg (R); (9) Kennelly (D); (10) Downey (D); (11) McGrath (R).

Energy and Commerce: (1) Waxman (D); (2) Bilirakis (R); (3) Rinaldo (R).

Others: (1) Roybal (D); (2) Pepper (D); (3) Yatron (D); (4) Schneider (R); (5) Ridge (R); (6) Mrazek (D); (8) Penny (D); (9) Miller of WA (R); (10) MacKay (D); (11) Panetta (D); (12) Leach (R); (13) Howard (D); (14) Seiberling (D); (15) Regula (R).

Senator HEINZ. I am pleased that, in addition to attracting support on both sides of the Hill, S. 2331 is supported by a wide range of senior advocate and provider groups. These include the American Association of Retired Persons, the American Society of Internal Medicine, the American Nurses Association, the National Council of Senior Citizens, and the National Association of Home Care.

What is the purpose of the bill? It is to improve the quality in hospital and posthospital settings and ensure greater access to posthospital services. The purpose of the bill, however, is not to dismantle prospective payment; and we don't propose a new layer of redtape or burdensome regulation on providers. On the contrary, what I like to think that the bill does is to darn some holes and repair some flaws in the existing Medicare and Medicaid laws.

I don't have to tell you, Mr. Chairman, that back in 1983 when we acted to save the financially strapped Medicare system, prospective payment was a key part of that strategy. We had good confidence and good reason for that confidence that the new reimbursement method could halt the spiralling costs of health care. In 1985, there was only a 6-percent increase in hospital costs—the lowest rate of increase in 20 years. That part of PPS has been extremely successful.

We also, at the time—and you took the lead in this, Mr. Chairman—recognized that PPS contained inherent incentives to cut back on the level and quality of care provided to patients.

I remember all those hearings that you held on PSRO's and your work to develop the PRO concept. I don't think that was in the original administration plan. And you had an interest in this long before any of the rest of us saw what might be coming. As a result, we did create and charge the peer review organizations with the responsibility of monitoring quality of care and sanctioning providers who place high profits above good medical practice. The bad news—and you will hear it from even more expert witnesses today—is that within a year of implementation, many physicians and many consumers were becoming concerned that PPS, in fact, did pose a threat to the quality of care for Medicare beneficiaries and particularly for the oldest and sickest of those beneficiaries.

I said earlier that the Senate Aging Committee spent about 16 months looking into quality of care under PPS. We got evidence from the General Accounting Office and many others; time really doesn't permit me to describe everything in that investigation. I would thus like to summarize what we concluded in its shortest form.

Our most disturbing evidence showed that there were widespread problems and more specifically, first, that there are too many instances of hospitals pressuring doctors to keep ill people out of the hospital and to discharge others, often in an unstable condition. That is an inappropriate discharge by anybody's definition.

Second, patients and their families often receive false or incomplete information regarding their rights—the rights of appeal, for example—under the new system.

Third, the PRO's only have a tiny snapshot of the big picture of quality, and they feel hamstrung by what they describe as, and I quote the head of the PRO organization, "restricted, underfunded, inflexible, and narrowly focused," review program that is all of those things.

And too often, in addition to the first three items, patients are discharged into an inappropriate setting after their discharge from the hospital for the right kind of followup care.

Fifth, almost one-third of the Nation's skilled nursing facilities, into which many of these people are discharged, are substandard. They have failed to meet at least one basic Federal standard to ensure that the health and safety of nursing home residents is safeguarded. And there has been, I am sorry to say, a dramatic increase in the number of nursing homes cited for violating Federal standards; and that signals an alarming deterioration in the quality of care for some 2 million nursing homes.

Bill Roper testified on this subject about 2 weeks ago, and I think he would not dispute that there has been a deterioration. He agreed that there was. We can all guess as to why, but it poses a serious problem.

And finally, the Department of Health and Human Services and HCFA have failed to collect the type of data necessary to assess the extent to which PPS is having harmful effects on quality and access to care. This last issue was most systematically revealed in a GAO study, which I am happy to be able to release today; and I am very pleased that the principal author who testified at one of our earlier hearings, Eleanor Chelimsky, has been invited to testify today. She is a real expert, the kind of person that we are very lucky to have in the Federal Government. I look forward to hearing what she has to say today to build on her previous record.

Mr. Chairman, I do not believe that the American people want substandard medical care for their parents and grandparents; and so, it is imperative that we act. Why? Because, first, it is the right thing to do; and second, our failure to act is ultimately going to undermine the prospective payment system and therefore the financial stability of Medicare. Thus, I believe, that the Medicare Quality Protection Act, with which I don't have to familiarize you as one of the authors and coauthors and cosponsors, is a major step forward in solving these serious quality of care problems. It makes needed adjustments in Medicare's hospital prospective payment system, and the peer review process to improve the quality of care in acute and postacute facilities. And it also improves patients' access rights to needed posthospital care, protects and expands patients' rights in hospitals, and improves coordination among those Federal agencies responsible for the health care of our Nation's elderly.

I guess one or two last words should be said. I don't believe that the quality of care under the DRG system can be addressed without a comprehensive strategy. And we in Congress, I gather, are going to have to be the ones to do that because, listening to what Bill Roper had to say, they just don't seem to see downtown that there are some serious problems.

Therefore, I think we are going to have to enact just as quickly as possible the Medical Quality Protection Act or something very much like it if we are going to restore public confidence in the Medicare system and assure quality health care. One criticism that has been leveled at the bill is that it costs some money. Mr. Chairman, it does cost money. I will be honest about that. The Congressional Budget Office—and I don't dispute their statistics—has estimated on a preliminary basis that, over a 3-year period, the bill will cost $200 million.

That is one-tenth of 1 percent of the amount—more than $200 billion—that Medicare is going to spend over the same period. Or if you want to look at it another way, the prospective payment system is saving the Medicare Program between $3 and $4 billion a year. We would be plowing back less than $70 million of that $3 to $4 billion savings a year into protecting quality and access care. I submit this is not only a worthwhile investment; it is also a vital insurance policy to keeping the system working, working well, and safeguarding the Medicare Program.

There is a summary of the major findings of the Special Committee on Aging and the key provisions of the Medicare Quality Protection Act that I would like to submit at the conclusion of my statement, and I ask unanimous consent that they be so included.

Senator DURENBERGER. Without objection.

Senator HEINZ. And I would also request that copies of the staff reports from the three hearings which the Senate Special Committee on Aging held last fall, be included in the hearing record.

Senator DURENBERGER. Yes, we will include it in the record of the hearing.

Senator HEINZ. Mr. Chairman, let me just say again in conclusion that I am really delighted with your initiative on this matter. It is, to my mind, extremely important that we focus on both the acute care discharge problems and also the long-term and posthospital side of the health care system.

I mentioned some problems that we are seeing with nursing homes. We don't address those in the Medical Quality Protection Act. I will soon be introducing a bill to propose some solutions to those very serious quality of care problems that exist in those settings, and I hope that you will work with me as you did on S. 2331, and that you will give it your serious study, and if you so desire, your support, because I think we have as big a problem there as perhaps we have with the problems that our existing bill addresses.

I want to thank you, Mr. Chairman, for this opportunity to testify, and I would be happy to answer any questions.

Senator DURENBERGER. John, thank you very much.

[The summary of major findings and the staff reports of the hearings follow:]

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

Summary of Committee Recommendations

Staff Report

Full Report Available from:
Special Committee on Aging,
United States Senate
John Heinz, Chairman

September 26, 1985

SUMMARY OF COMMITTEE RECOMMENDATIONS:

Recommendation 1: Congress should promptly enact a set of adjustments to the DRG classification system similar to those recently developed at Johns Hopkins University to better reflect differences in severity of illness between patients in the same DRG category.

Recommendation 2: The Secretary should immediately remind Medicare certified hospitals of the illegality, under Section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the HHS Office of Civil Rights.

Recommendation 3: The Secretary should revise the PRO scope of work, now being drafted by HCFA for the second round of PRO contracts, to require comprehensive quality assurance monitoring and enforcement activities.

Recommendation 4: Congress should pass S. 1623, now incorporated in the Senate Reconciliation package, which would for the first time authorize PROs to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PROs.

Recommendation 5: Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization review, and which will reflect as well the greater cost per quality review conducted by PROs.

Recommendation 6: Congress should mandate that HHS require a clearly defined appeals procedure for grievances associated with quality for patients, providers and the PROs. The procedures should be consistent and clearly published in PRO and provider manuals. Medicare patients' informed consent forms should clearly include their rights and responsibilities under the prospective payment system.

Recommendation 7: Expand existing law, which provides for "Administratively Necessary Day" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, to provide for such payments when no appropriate post-hospital placement -- in terms of level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 8: PROs' responsibilities for quality assurance should be extended so that they are required to track a prespecified percentage of patients discharged from the hospital through the continuum of nursing home, home health and other community-based services.

Recommendation 9: Congress should create within each state a Consumer Advisory Board (CAB) to conduct oversight of the PROs, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The Board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each Board would be required to make annual reports to the governor and to DHHS. DHHS would be required to utilize CAB input in its decisions to award PRO contracts. The CAB should consist of the long-term care Ombudsman, and Protection and Advocacy officials of each state, and organizations representing the elderly and disabled.

Recommendation 10: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, Health Care Financing Administration (HCFA), Prospective Payment Assessment Commission (ProPAC), American Medical Peer Review Association (AMPRA), Department of Health & Human Services' Office of Inspector General (OIG), beneficiaries as well as health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

Summary of Committee
Recommendations

Staff Report

Full Report Available from:
Special Committee on Aging,
United States Senate
John Heinz, Chairman

October 24, 1985

STAFF RECOMMENDATIONS.

RECOMMENDATION #1: Withhold portion of HHS appropriation for FY86 until PPS Impact on Nursing Homes report, with recommendations for reimbursement reform (due 12/31/83), and first Annual PPS Impact Report (due 12/31/84) are delivered to Congress.

RECOMMENDATION #2: **DHHS should voluntarily suspend plans to deregulate hospital quality assurance** until it reports to Congress on the impact of PPS.

RECOMMENDATION #3: **Eliminate current "level of care" distinctions governing nursing home reimbursement under Medicaid,** concurrently with mandatory State phase-in of a reimbursement system based upon patients' individual needs and characteristics.

RECOMMENDATION #4: **Expand advocacy assistance for older Americans.** (1) **Authorize** Long Term Care Ombudsman to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; Mandate State Ombudsman representative on PRO advisory or corporate board; (2) **Fund training** of Ombudsmen in (a) Medicare PPS and (b) all Medicare Part A appeals; (3) **Establish** funding formula for Ombudsman programs based upon workload; (4) **Provide** Ombudsmen with immunity from suits for good faith performance of duties.

RECOMMENDATION #5: **Improve Protections for Nursing Home Residents.** Congress should enact a minimum set of sanction authorities, which would: (1) **Empower** State enforcement officials to impose receivership on substandard nursing homes, (2) **Provide** Federal Financial Participation (FFP) for care of residents during the period of a receivership; (3) **Strengthen** the Patients' Rights; (4) **Authorize** States to impose civil penalties and suspend reimbursement at noncompliant providers; (5) **Expedite sanction** & provider appeal at chronically substandard nursing homes; (6) **Prohibit discrimination** in admission or treatment of patients based on source of payment; (7) **Empower residents** to enforce provider agreement with private right of action; (8) **Impose moratorium** on HCFA's scheduled January 1986 implementation of new nursing home inspection survey system ("PACS"), for public review and comment.

RECOMMENDATION #6: Authorize and fund PROs to do expanded quality of care reviews to (1) nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) Increase PRO reviews of readmissions to those occurring within period 30 days.

RECOMMENDATION #7: Restructure Medicare's eligibility determination and appeals process. (1) Adopt uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities; (2) **Institute PRO pre-discharge** eligibility determination for Medicare and Medicaid benefits, with opportunity for patients to initiate appeal prior to discharge; (3) **Eliminate 3-day** prior hospitalization requirement for Medicare SNF benefit; (4) **Mandate appeal** opportunity for beneficiaries when provider fails to submit claim; (5) **Create penalties** for fiscal intermediaries or PROs that improperly deny benefits; (6) **Retain Waiver of Liability** protections for providers.

RECOMMENDATION #8: Congress should upgrade Federal rules for hospital discharge planning to include (1) **Pre-discharge consultation** between all professionals giving care to the patient; (2) **Inform beneficiaries**, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care Ombudsman and (d) nearest location of deficiency reports on local providers under consideration for placement of the patient.

MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

Summary of Committee
Recommendations

STAFF REPORT
Full Report Available from:
Special Committee on Aging,
United States Senate
John Heinz, Chairman
November 12, 1985

IMPROVING HOSPITAL DISCHARGE PLANNING

Recommendation 1: Expand existing law, which provides for "Administratively Necessary Days" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, and to provide for such payments when no appropriate post-hospital care placement -- in terms of the level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 2: Congress should upgrade Federal rules for hospital discharge planning to include (1) pre-discharge consultation between all professionals giving care to the patient; (2) informing beneficiaries, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care ombudsman and (d) the nearest location of deficiency reports on local providers under consideration for placement of the patient.

Recommendation 3: DHHS should voluntarily suspend plans to deregulate hospital quality assurance and discharge planning until it reports to Congress on the effects of PPS.

EXTEND QUALITY PROTECTIONS TO POST-ACUTE CARE SETTINGS

Recommendation 1: PROs' responsibilities for quality assurance should be extended so that they are required to track a pre-specified percentage of patients discharged from the hospital through the continuum of nursing home, home health, and other community-based services.

Recommendation 2: Authorize and fund PROs to do expanded quality of care reviews (1) of nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) increase PRO reviews of readmissions to those occurring within a period of 30 days.

Recommendation 3: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, the Health Care Financing Administration, the Prospective Payment Assessment Commission, the American Medical Peer Review Association, the Department of Health and Human Services' Office of the Inspector General, beneficiaries, and health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital settings, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.

PROTECTING QUALITY CARE IN NURSING HOMES

Recommendation 1: Improve protections for nursing home residents. Congress should enact a minimum set of sanction authorities, which would (1) empower state enforcement officials to impose receivership on substandard nursing homes; (2) provide federal financial participation for care of residents during the period of a receivership; (3) strengthen patients' rights; (4) authorize states to impose civil penalties and suspend reimbursement to noncompliant providers; (5) expedite sanction and provider appeal at chronically substandard nursing homes; (6) prohibit discrimination in admission or treatment of patients based on source of payment; (7) empower residents to enforce provider agreement with private right of action; (8) impose moratorium on HCFA's scheduled Janurary 1986 implementation of new nursing home inspection survey system ("PACS"), for public review and comments.

Senator **Durenberger**. Just two brief questions. One is one I wasn't able to get into with Bill Roper. It would strike me that there are populations, as you indicated, that are particularly susceptible to the problem that is inherent in the prospective payment system—the frail elderly, for example; the chronically ill, another example; maybe the indigent, I am not real sure on that; or people that live in communities in which the hospital itself is hard pressed, absent the nature of DRG—rural communities, for example.

In your analysis, that your committee has been looking at for the last 16 months, does that pinpoint to any degree the specific populations among the elderly that are especially susceptible to these quality problems?

Senator **Heinz**. I think you have put your finger on the principal characteristic of what is becoming known as the "DRG loser," which is the older, sicker, frailer elderly individual who tends to suffer from more than one illness. He or she may have high blood pressure and a heart condition and other complicating conditions; these are the type of individuals who, from our testimonies and from our analyses, seem to be most at risk. As to their geographic distribution, I really can't give you a very good analysis of the extent to which they are rural or urban at this point. They tend simply to have more than one illness or condition.

The hospitals are being reimbursed for one illness, not many; therefore, these people tend to be the most at risk of being discharged sicker than I think, in some cases, we would desire. Second—this can't be overemphasized—there is an enormous increase in discharges into either home health care or nursing homes. It looks to be in the neighborhood of a 40-percent increase in discharges under PPS.

There is a shortage of nursing home beds. We have tightened up substantially on the reimbursement for home health care. And one of the reasons that we need to broaden our snapshot as to what happens to people once they get out of the hospital is so we have some idea as to whether people are being properly taken care of after they go out of the hospital's doors.

I am very concerned that what we call "skilled nursing facilities," which may be adequate for somebody who has a chronic illness, are really woefully unprepared to handle postacute care cases who are in a much more delicate health situation than somebody who is suffering from rheumatoid arthritis and/or Alzheimer's or some other long-term disease. And as a result, I really have a lot of worries about the kind of health care services that we have out there to care for people upon discharge. I am not sure that they are up to it.

This has nothing to do with whether the SNF is a good nursing home or a bad nursing home. It is whether the SNF is trained to handle people who are coming in there with their IV still more or less attached.

Senator **Durenberger**. John Chafee?

Senator **Chafee**. I have no questions, Mr. Chairman. Thank you.

Senator **Durenberger**. John, thank you very much.

Senator **Heinz**. Mr. Chairman, thank you.

Senator **Durenberger**. We appreciate it a great deal.

John, would you like to make your statement?

Senator **Chafee**. Thank you, Mr. Chairman. I know we have quite a list of witnesses here, so I will truncate my statement, except to say that ever since we developed the prospective payment system, I have been concerned about it.

Obviously, the thrust of the system was directed against the rapidly increasing costs of health care and especially the escalation of costs of the Medicare Program. And there is no doubt that the system has been effective in containing those costs. However, it seems to me that our zeal in cost containment must be balanced against our concern about maintaining the quality of health care for our senior citizens.

And Mr. Chairman, I applaud you for holding this hearing today to look into the questions.

It seems to me that we are dealing with very serious questions here and I look forward to hearing the witnesses on them. I have already cosponsored a variety of legislative proposals which address some of these problems, and I have joined with Senator Heinz and others in support of the Medical Quality Protection Act of 1986, S. 2331. I think a particularly important part of that piece of legislation is the requirement for hospitals to provide discharge planning to ensure the continuity of patient care.

Mr. Chairman, I also want to say that this is only the first step in tackling what I consider to be a much bigger problem, and that is long-term care. I am convinced from my contact with senior citizens—and I suspect that you would corroborate this—that the single most worrisome matter for our senior citizens is: Will they have adequate financial support for health care services, especially long-term care?

At present, we have no systematic coverage to help patients with the catastrophic costs of long-term care. Neither Medicare nor private insurance provide that financial assistance. Therefore, our elderly are confronted with the worry that if they become afflicted with a long-term illness their financial resources will be depleted, and they will become impoverished before they can qualify for the only other available source of assistance, which is Medicaid.

It seems to me that we must develop alternatives to Medicaid, drawing on both private and public sources to help pay for long-term care. This hearing is a step toward understanding these problems and hopefully will lead to a solution. So, Mr. Chairman, I think it is well that we are having this hearing.

Senator **Durenberger**. John, thank you very much.

Let us now call the panel of Michael R. Goldwyn, the executive director of the Northwest Oregon Health Systems in Portland; Cynthia Polich, the executive vice president of InterStudy; Mark Russell Chassin, the project leader of the Rand Corp.; and Dr. Gerard Anderson, the associate director of the Center for Hospital Finance and Management at Johns Hopkins.

Cynthia, are you not trying to make the 11:45?

Ms. **Polich**. I am supposed to be back in Minneapolis for a preinvitation of the Group Health Association meeting.

Senator **Durenberger**. Which is the flight you are trying to make?

Ms. **Polich**. The 12:15.

Senator DURENBERGER. Oh, the 12:15?

Ms. POLICH. Yes.

Senator DURENBERGER. You have got lots of time.

Ms. POLICH. No problem. [Laughter.]

Senator DURENBERGER. Go ahead, Mike. [Laughter.]

Mr. GOLDWYN. Mr. Chairman, shall I start or Ms. Polich?

Senator DURENBERGER. You can stay here until what time, about quarter to or so?

Ms. POLICH. About quarter to.

Senator DURENBERGER. All right. John Chafee wants to get rid of you, so——

Senator CHAFEE. No, no, no. There is no helicopter waiting outside for you.

Senator DURENBERGER. All right. By popular demand, Cynthia Polich from InterStudy is going first, so she can get back to Minnesota.

STATEMENT OF CYNTHIA L. POLICH, EXECUTIVE VICE PRESIDENT, INTERSTUDY, EXCELSIOR, MN

Ms. POLICH. Thank you very much. I am Cynthia Polich. I am executive vice president of InterStudy and director of their Center for Aging and Long-Term Care.

InterStudy is a nonprofit health care research organization located just outside of Minneapolis. My remarks today are based upon work that we have done over the past 9 months on transitional or subacute care currently being provided to Medicare beneficiaries in Minnesota. We have defined transitional care as care provided the patients during the transition between acute care and discharge to the home or permanent placement in a nursing home. Issues related to the provision of transitional care are relevant to today's hearings because it is believed that the development of transitional care services is directly related to the incentives created by the DRG system for hospitals to discharge patients as soon as possible.

There are several concerns related to the provision of transitional care and the DRG reimbursement system. First, the appropriateness of hospital provision of transitional care; second, the gaps in access to transitional or subacute care services; and finally, who should fund these services.

In an effort to save some time here, I would like to get to what I think are the two most important issues, those related to the gaps in access to these services and funding.

The gaps in access to transitional care services, I believe, is one of the most important and biggest problems with the provision of transitional care services. In Minnesota, 66 percent of the hospitals and 62 percent of nursing homes reported providing transitional care. The facilities most likely to provide transitional care include hospitals with attached nursing homes, nursing homes with all three levels of care, Medicare certified nursing homes, swing-bed hospitals, and hospitals with under 40 percent occupancy rates. However, even with the widespread provision of transitional care in Minnesota, it is not universally available to all of Medicare beneficiaries.

More importantly, there is tremendous variation among the States in the provision of transitional care to Medicare beneficiaries. What this points out, I think, is that it is not only the DRG reimbursement system that is the reason for the development and the provision of transitional care. It may not even be the primary reason. Other important factors determining whether providers in a State develop transitional care services include the nature of the long-term care system in a State and the health care environment in the State.

Minnesota's environment encourages the development of this level of care because Minnesota has an extensive long-term care system with a large number of nursing home beds, generous Medicaid dollars for long-term care and an extensive community-based service system. Also, Minnesota has a competitive health care environment with extremely low hospital occupancy rates and high HMO penetration among both the younger population and the Medicare population.

Currently, about 50 percent of the Twin Cities Medicare population is enrolled in HMO's. All of those factors, along with DRG reimbursement, creates a tremendous incentive for the development of transitional care services.

What this suggests to me is that the extent of the problem will vary tremendously from State to State. It also suggests that the appropriateness of current practice patterns of hospitals and nursing homes and the quality of transitional care services currently being provided is not the most important issue. The most important issue seems to relate to the adequacy of supply of transitional care services.

The final concern which is also of tremendous importance relates to the funding of transitional care services. There is currently an inadequate supply of transitional care services for the elderly due primarily to insufficient reimbursement mechanisms. What we are facing, I believe, is a dilemma of a growing need for a level of care that no one is willing to pay for. The DRG system, as with all capitated provider risk-based payment systems, creates incentives for efficient use of resources, including early discharge. Patients who no longer meet acute care criteria, however, may still require some care to completely recuperate from hospitalization.

These patients are now being treated in a variety of ways, depending upon the State in which they reside, the hospital, the alternative options available, and the condition of the patient. The patient can be transferred to a swing-bed, maintained in a hospital under the DRG, transferred to a hospital SNF bed, or community nursing home, maintained in the hospital in a special transitional care unit primarily on a private-pay basis, discharged to their home with home care services, or discharged to their home with no additional services.

The most appropriate option depends upon many different factors. This really highlights the need for competent discharge planning as well as more specific direction regarding our expectations of the system. We know that we want to decrease, if not eliminate, the no-care zone. We know we want to ensure that patients receive the care they need. Yet we also want to encourage the efficient use of health care resources, and we want to eliminate both underservice and overservice that can be detrimental to the patient.

My conclusion from our current work suggests that the problem is not only with the DRG reimbursement system. To a large degree, the system has met our expectations for reducing length of stay in hospitals and reducing costs, but it also has had a major role in creating a growing need for transitional or subacute care. Yet the growth in this market is not necessarily a negative implication of our changing health care system. The addition of transitional care to our health care continuum provides patients with more care options and a higher probability of receiving appropriate care.

The problem comes when this care is not universally available, primarily due to reimbursement constraints. Yet we must be careful about developing another level of care that, while meeting important needs of the elderly, adds substantial costs to the system. The essential problem, I believe, is that we have capitated one part of the Medicare system, creating incentives to move people into other possibly more lucrative levels of care that may be funded on a fee-for-service basis. The answer, in my view, is to fully integrate the full continuum of both acute and long-term care services for the elderly and finance it on a capitated basis with the provider at risk, not only for the hospitalization but for every part of the elderly patient's care.

I realize we are still a long way from achieving this kind of ideal. However, the Minnesota experience, I believe, suggests that capitation of Medicare can be a very effective way of reducing both cost shifting and reducing the perpetuation of a no-care zone. Thank you.

Senator DURENBERGER. Thank you very much. Mr. Goldwyn?

[The prepared written statement of Ms. Polich follows:]

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STATEMENT OF CYNTHIA L. POLICH
Executive Vice President
InterStudy

to the
Senate Finance Committee

June 3, 1986

Interdisciplinary studies for policymakers

Mr. Chairman, I am Cynthia Polich, Executive Vice President of InterStudy and Director of their Center for Aging and Long-Term Care. InterStudy has been best known over the past decade for its advocacy of HMOs as a promising method of reducing acute health care costs. In the past few years, InterStudy has become more involved in issues related to aging and long-term care. We are particularly interested in identifying and promoting strategies to contain costs and control utilization of long-term care services while creating incentives to encourage maximum independence among the elderly.

This past fall, InterStudy was asked by the Minnesota Association of Homes for the Aging (MAHA) and the Minnesota Hospital Association (MHA) to study transitional care in Minnesota, the issues and problems arising out of the provision of this care, and the need for public policy initiatives to deal with any problems. The study was commissioned for several reasons:

1) the tremendous interest in transitional care by the Minnesota legislature, state government officials, hospitals, and nursing homes;
2) the recent suggested conflict and competition between nursing homes and hospitals regarding the provision of transitional care;
3) concern over the lack of information and possible biases about what is actually happening in the area of transitional care; and
4) concern over the uncertainty about the definitions of transitional care.

This study is particularly relevant to the issues being discussed at this hearing because of the general belief that the development of transitional care services is directly related to the incentives created by the DRG system for hospitals to discharge patients as soon as possible.

My presentation today will examine the provision of transitional care in Minnesota. A few cautions must be made, however. First, the development of transitional care services and the response of hospitals and nursing homes to the DRG reimbursement system varies tremendously from state to state. Much depends upon the regulatory climate of the state, the nature of the state's long-term care system, the degree of competition within health care, the strength of certificate of need processes, and so on. Thus, the response of providers in each state to the DRG system generally, and their interest in developing transitional care services in specific, will be unique. It is doubtful whether the findings from this study are generalizable to the entire country. Second, while I will be using data from the MAHA/MHA study of transitional care in Minnesota, I in no way represent these organizations and my statements today do not reflect their positions.

This study began with several assumptions about transitional care. The first assumption was that there is a potential for significant competition between hospitals and nursing homes, and that nursing homes perceive that hospitals are encroaching on their long-term care market. It was also assumed that there may be inequities in the regulatory treatment of hospitals and nursing homes providing transitional care, in spite of the fact that they may be providing the same types of care. It was further assumed that there is concern about the appropriateness of care being provided in different settings. We also assumed that there is a great deal of confusion about what transitional care is and who provides it. In light of these assumptions, the study was intended to accomplish the following objectives:

1) to define transitional care and provide a description of the services and settings that are encompassed in the definition,
2) to describe the population currently using transitional care services,
3) to describe the settings in which transitional care is currently being provided,
4) to describe and analyze the funding sources and costs of these services,
5) to describe and analyze the barriers to providing these services in different settings, and
6) to provide up-to-date information about the provision of transitional care.

The study included a comprehensive literature review on the topic of transitional care, interviews with local and national experts in the area, and a survey of all hospitals and nursing homes in Minnesota.

Transitional Care in a Changing Health Environment

Over the past decade, major changes have occurred in health care. Particularly in acute health care, the system has been characterized by increased competition and cost containment. All health care payors, whether government, insurance companies, employers, or HMOs, have forced providers to be much more cost conscious. The most striking example recently has been the change in Medicare hospital reimbursement to the Prospective Payment System (PPS).

This type of reimbursement is not new to the health care system. Health maintenance organizations have, for decades, provided a full array of acute health services to their enrollees at a fixed, capitated cost. The increased prevalence of fixed cost per case reimbursement, however, does have both intended and unintended outcomes. The intended outcomes are to place the providers at risk for the costs of a patient's care, reduce inpatient hospital admissions and shorten lengths of stay, encourage the use of cheaper, less intensive medical services (e.g., outpatient surgery), and reduce the aggregate costs of the health system. The unintended consequences could include reducing the financial viability of hospitals (particularly small, rural hospitals), reducing the delivery of needed care, and changing the provider configuration of the health care system.

The provision of transitional care may be one of the unintended consequences of changes in the health care reimbursement system. There are clearly strong incentives on the part of the hospital to discharge patients as soon as possible. Many of these patients may, however, continue to need some level of sub-acute care before they can return home. To respond to this need, hospitals are converting unused hospital beds to hospital-based skilled nursing facilities, developing special transitional care units, and seeking Medicare swing bed certification. Nursing homes are also providing more post-hospital care. Anecdotally, nursing home administrators report that the disability levels of residents admitted from hospitals is much higher since the implementation of the DRG reimbursement system.

Combined with changes in reimbursement are other systemic changes which have injected more competition into health care. The result has been reductions in hospital occupancy rates, diversification into alternative services, cost competition, and the consolidation of hospitals into larger systems. All of these forces have created a climate that is very well-suited for the development of transitional care. Questions must be addressed, however, regarding the overall impact of this direction. What will be the impact on the long-term care system if hospitals enter this market? What role should nursing homes have in this changing climate? What will be the ultimate impact on the quality of patient care? Does transitional care simply shift costs from traditional payors to the patient, or is it a new level of care that actually expands the continuum?

Definition of Transitional Care

One of the first issues addressed by this study was the definition of transitional care. We found that transitional care is an extraordinarily nebulous term. We found no existing clear definition. The only component of a definition that is universally accepted is "short length of stay". How that is defined, however, differs from facility to facility -- ranging from just a few days to two months.

Transitional care appears to be a subset of a larger group of services called "sub-acute care". Sub-acute care includes a range of alternative services that are typically provided by hospitals. They are generally part of a diversification strategy which moves the hospitals beyond their current focus of providing only inpatient hospitalization. These services may include respite care, hospice care, transitional care, and pre-hospital "hotel" services.

For purposes of our survey of nursing homes and hospitals completed for this project, transitional care was defined as "care provided to patients or residents during the transition between acute care and discharge to the home or permanent placement in a nursing home". The findings of the survey and the research conducted for this project confirmed the appropriateness of this definition. It was found, however, that the definition could be further elaborated. The diagram on the following page provides a definition and typology of transitional care in Minnesota.

As noted in the typology above, we defined institutionally based transitional care as 1) care received after an acute, inpatient hospitalization, 2) that is needed before the patient can return to permanent residence, 3) is a short length of stay, and 4) does not include respite care, hospice care, or pre-hospital "hotel" services. The typology also shows that there are significant differences in the definitions of transitional care as perceived by hospitals compared to nursing homes. Hospitals describe their transitional care (seen as Level 1) as short-term (less than two weeks), medically intensive, sub-acute care after an inpatient hospitalization. They report that their transitional care patients still need significant medical services from physicians and nurses. Nursing homes, on the other hand, describe their transitional care services (seen as Level 3) as short-term (15-60 days) rehabilitation after an inpatient hospitalization. Typical transitional care residents in a nursing home are medically stable but require more intense rehabilitation services before they can return home. This information suggests that, while nursing homes and hospitals both use the term transitional care to describe a special type of care they provide, they are actually providing very different services to different types of patients.

The third type of transitional care (seen as Level 2) is a very different service. It is characterized by light nursing care and a length of stay of only 2-3 days. The patient is medically stable but needs to stay in the hospital for a few days, primarily for convenience. This type of transitional care is used when the patient is waiting for home care to be arranged or a nursing home placement, or must travel a long distance to return home. Payment is almost always out-of-pocket by the patient. While this level can, and is, provided by both nursing homes and hospitals, it is most often provided by hospitals.

Results of Minnesota's Transitional Care Survey

A major part of this project was a survey of all Minnesota nursing homes and hospitals. The intention of the survey was to determine what facilities are current doing in the area of transitional care. A total of 602 surveys were sent with 334 returned -- a response rate of 55.5%. There was approximately a 73% response rate for nursing homes and hospitals that were members of the two associations sponsoring this survey. 196 nursing homes responded to the survey compared to 126 hospitals. Of this group, 50 facilities were combined nursing homes and hospitals. Other characteristics of the responding facilities include that:

- 75% of the responding facilities were located outside the seven-county Twin Cities metropolitan area;
- almost half of the responding nursing homes provide all three levels of care -- SNF, ICF-I, and ICF-II levels of care;
- over two-thirds of responding nursing homes WERE NOT Medicare-certified;
- a slight majority (53%) of the hospitals were designated as swing bed hospitals;

Definition of Institutionally Based Transitional Care

1) Care received after an acute, inpatient hospitalization.

2) Care needed before patient can return to permanent residence.

3) Short length of stay.

4) Does not include respite care, hospice care, or pre-hospital "hotel" services.

Typology of Levels of Transitional Care

INPATIENT HOSPITALIZATION

Level 1	Level 2	Level 3
• Medically intensive sub-acute services • Patient typically requires high physician & nurse contact • Usually less than 7 days, but no more than 14 days • **Typically provided by hospitals with acute license or swing bed** • Usually private payment, sometimes Medicare • Can be provided by Medicare-certified SNF with high nursing hours	• Light nursing care • Patient medically stable • Usually 2-3 days • Usually for consumer convenience • Usually private payment • Can be provided by either hospitals or nursing homes, but usually hospitals	• Rehabilitation after hospitalization • Patient medically stable • Moderate to low nursing hours, high therapist hours • 15 to 60 days, usually no more than 30 days • **Typically provided by nursing homes** • Usually private payment or Medicare, sometimes Medicaid • Can also be provided in special rehab units in hospitals

- the majority of both hospitals and nursing homes were relatively small, with over 60% of hospitals having under 50 beds and almost 70% of nursing homes having under 100 beds; and
- two-thirds of the responding hospitals had occupancy rates under 40% while over 90% of nursing homes had occupancy rates of 91-100%.

As mentioned above, for purposes of the survey, transitional care was defined as "care provided to patients during the transition between acute care and discharge to the home or permanent placement in a nursing home". Given this definition, almost 64% of the respondents reported providing transitional care. A slightly higher proportion of hospitals reported providing transitional care compared to nursing homes -- 66% compared to 62%. We also found that certain types of facilities are more likely to provide transitional care. They include:

- hospitals with attached nursing homes,
- nursing homes with all three levels of care,
- Medicare-certified nursing homes, and
- swing bed hospitals.

The number of licensed beds in the facility and the occupancy rate were also very important characteristics in determining whether a facility provided transitional care. Survey results show that 81% of hospitals with less than 50 beds provide transitional care while only 40% of hospitals with more than 50 beds provide transitional care. Similar findings are shown when examining occupancy rates. Over 71% of hospitals with occupancy rates under 30%, and 70% of hospitals with occupancy rates between 31-40%, provide transitional care compared to only 55% of hospitals with occupancy rates over 40%.

Size and occupancy rates are not as important for nursing homes in determining whether a facility provides transitional care. Larger nursing homes are slightly more likely to provide transitional care, and those nursing homes with less than 90% occupancy rates are slightly more likely to provide transitional care than those with occupancy rates over 90%. Other findings about the provision of transitional care include that:

- The vast majority (85%) of facilities do not provide transitional care in a special unit.
- 34% of the respondents reported that they do not currently provide transitional care. Only 14% of those indicated that they had future plans to provide transitional care.
- The primary funding sources for transitional care were Medicare and private out-of-pocket payment.
- Swing bed hospitals were twice as likely to provide transitional care compared to non-swing bed hospitals.
- Transitional care patients comprise a very small proportion of total patients or residents in a facility. Overall, 80% of all respondents indicated that only 0-10% of their patients would qualify under our definition of transitional care.

Major Findings and Conclusions

There is no question that the issues of transitional care are, and will continue to be, extremely important as the health and long-term care systems continue to emphasize cost containment and efficiency. Our society is now is the very early stages of learning to deal with fixed cost per case reimbursement mechanisms and increased competition in health care. Incentives are being created, primarily through reimbursement mechanisms, to reduce utilization, reduce costs, and diversify into other service areas. For hospitals especially, low occupancy rates and pressure from payors will continue to push facilities to seek out creative solutions. With an increasing elderly population, it is not surprising that this group is often the target of diversification strategies.

These incentives (and the knowledge that some hospitals have already responded to them) have created a great deal of apprehension on the part of nursing homes. Nursing homes in Minnesota are highly regulated. They have not had the opportunities to benefit from (or be hurt by) the increased competition that is now standard in the acute health care system. They fear the increased encroachment of hospitals into long-term care as hospitals are forced to expand and diversify in order to survive. State policymakers are also worried that a large movement by hospitals into the long-term care area will erode the effectiveness of current long-term care policies intended to control growth and costs. There is a corresponding concern regarding quality of care. It is unclear whether both nursing home and hospital settings are appropriate for providing transitional care.

When re-examining the assumptions with which we began this project, we found that there are currently large discrepancies between reality and conjecture. There is no question that current changes in reimbursement mechanisms for health care create an incentive for hospitals to diversify. In addition, the DRG system has created incentives for shortened lengths of stay in acute care. While, from a strict definition of acute medical necessity, many of those earlier discharges may be appropriate, those patients may still require additional care before they can return to their home. This care is now called "transitional care". Prior to DRGs, it was often a part of the acute hospital stay.

While there is certainly the potential that hospitals will move in the direction of providing long-term care, there is little evidence of this today. In fact, this study found significant differences in the definition of transitional care as perceived by hospitals compared to nursing homes. There is clearly some overlap between transitional care services provided in hospitals versus nursing homes, but the overlap appears small. There are some nursing homes that provide very intensive, sub-acute medical services to post-hospital patients, and there are some hospitals that provide longer term rehabilitation services. These cases, however, are the exception, not the rule.

This also suggests that what we are currently calling transitional care is nothing new. Hospitals have always provided medically intensive, sub-acute care but have only recently been required to separate it from the acute inpatient hospital stay for reimbursement reasons. Nursing homes have always provided short-term rehabilitation after a hospitalization, primarily through the Medicare program. **It appears that current interest and concern over transitional care is more a function of changes in reimbursement mechanisms than of changes in practice patterns of hospitals and nursing homes.**

On the basis of the research for this study, we concluded that many of our assumptions are incorrect. There is currently not a great deal of competition between hospitals and nursing homes for transitional care patients because they are providing very different services to different types of patients. Hospitals are not currently encroaching on the nursing home market but are limiting their activities to very short stay, sub-acute services after an inpatient hospitalization. Given this, nursing homes are not currently in a disadvantageous regulatory position because they are not currently competing for the hospital's transitional care market. Because of the significant differences in the types of transitional care being provided by hospitals and nursing homes, there appears to be no significant problems with inappropriate care in inappropriate settings. **The current problem then is not changes in practice patterns among hospitals and nursing homes, but rather, changes in reimbursement systems that encourage that behavior.**

At present, hospitals and nursing homes appear to be continuing to provide the type and level of care they have historically provided. It is suggested, however, that there are more people who need transitional care because of incentives for earlier hospital discharge. If this is the case, the issue is not the quality of care and appropriateness of current practice patterns of hospitals and nursing homes. The important issue is whether there is an adequate supply of needed transitional care services and, if not, whether anything can or should be done to encourage further development.

The DRG system, as with all capitated, provider risk-based payment systems, creates incentives for efficient use of resources, including early discharge. Patients who no longer meet acute care criteria may still require care to completely recuperate from the hospitalization. Those patients are now being treated in a variety of ways, depending upon the state, the hospital, the alternative options available, and the condition of the patient. The patient can be:

1) transferred to a swing bed,
2) maintained in the hospital under the DRG,
3) transferred to a hospital-based SNF bed,
4) transferred to a community nursing home,
5) maintained in the hospital in a special transitional care unit (typically on a private pay basis),
6) discharged to their home with home care services, or
7) discharged to their home with no additional services.

The most appropriate option depends upon the condition of the patient, the availability of alternatives in the community, the options available within the hospital, the availability of informal support for the patient at home, and the reimbursement options available. For example:

1) Are community nursing home beds available?
2) Does the community nursing home have the capacity to deal with the patient's needs?
3) Are there adequate home care services available?
4) Does the patient have family that can monitor any changes in condition and organize needed care?
5) Does the hospital have alternative services that can be provided?
6) Is there insurance coverage for this type of care? Are there services available that Medicare will reimburse (through swing beds, SNFs, or home health care)? Can the patient pay privately?

These questions highlight the complexity of these issues. They also highlight the need for competent discharge planning as well as more specific direction regarding our expectations of the system. We know that we want to decrease, if not eliminate, the "no care" zone. We know we want to insure that patients receive the care they need. Yet, we also want to encourage the efficient use of health care resources. We want to eliminate both underservice and overservice that can be detrimental to the patient.

My conclusion from current work suggests that the problem is not necessarily with the DRG reimbursement system. To a large degree, this system has met our expectations for reducing length of stay in hospitals and reducing costs. But it has also had a major role in creating a growing need for transitional or sub-acute care. It should be noted, however, that many other forces within the health care system are also having a significant role in encouraging providers to develop transitional care services.

Yet, the growth in the market for transitional care is not necessarily a negative implication of our changing health care system. The addition of this level of care to our health care continuum provides patients with more care options and a higher probability of receiving appropriate care. The problem comes when this care is not universally available, primarily due to reimbursement constraints. We are faced with the dilemma of a growing need for a level of care that no one is willing to pay for.

1) Hospitals feel that this is a separate level of care that should not be paid through the DRG.
2) The Medicare program includes several possible avenues for financing transitional care through swing beds, Medicare-certified SNFs (whether hospital- or community-based), and home health care. Yet, the access to and availability of these options is limited by varied interpretations of fiscal intermediaries, reductions in spending for home health care, limited numbers of Medicare-certified SNFs, state certificate of need programs and moratoriums that constrain the development of SNFs, and restrictions on swing beds to small rural hospitals. Thus, Medicare financing is not always available for patients who need transitional care, even though, technically, the services are covered.
3) Many people can and are willing to pay for transitional care "out-of-pocket" either in a hospital setting, in a community nursing home, or through home health care. Yet, clearly this is not an option for all.
4) Some insurance companies and HMOs will finance transitional care if it results in a clear cost savings, but this too is limited.

Thus, the "no care" zone is more a function of insufficient funding sources for transitional care and insufficient direction regarding how this care should be financed.

STATEMENT OF MICHAEL R. GOLDWYN, EXECUTIVE DIRECTOR, NORTHWEST OREGON HEALTH SYSTEMS, PORTLAND, OR, ACCOMPANIED BY MERILYN F. COE, DR. P.H., PRINCIPAL INVESTIGATOR; AND ANNE M. WILKINSON, M.S., PROJECT DIRECTOR, NORTHWEST OREGON HEALTH SYSTEMS, PORTLAND, OR

Mr. GOLDWYN. Thank you, Mr. Chairman and members of the committee. My name is Michael Goldwyn. I am executive director of Northwest Oregon Health Systems, which is the health systems agency for the Portland metropolitan area.

With me today on my right is Anne Wilkinson, who is a research director for our agency, and on my left is Dr. Merilyn Coe, who is our principal investigator on the discharge project. Our testimony today is to describe to you our findings in the dependency at discharge project, which we undertook—we began over a year ago—and have just finished and published our report.

Our observation was, back in December of 1984, that the change to Medicare prospective payment and DRG's was a major shift, the most interesting topic in health care, and that there was ample attention being paid to the financial and organizational impacts of it; but inadequate attention being paid to the impact on patients.

Our intention was to create a study which would in fact assess in a statistically valid and methodologically sound fashion the question of: Were patients being discharged quicker? Were they being discharged sicker—in our terms, sicker in terms of indicators of self-care—dependency and self-care? And could we develop a research tool that would be useful, not just for our research project, but also for discharge planners, social workers, Government agencies, and researchers in assessing patient status at the point of discharge from the hospital?

We began the project in early 1985, developing the tool in conjunction with Patricia Patterson, who is a faculty member at the Oregon Health Science University School of Nursing. And in October of 1985, we were delighted that we received a grant from HCFA to continue and enlarge the study.

The two goals were essentially again to go beyond the anecdotal information that was available about quicker and sicker issues, with a methodologically sound approach and to develop a research instrument which would be useful both to the project and for discharge planners, social workers, and other people.

Before I describe the findings, I want to properly and carefully describe the limitations of the study, which is a requirement in reporting research. There were several we had. One was the inherent fallibility of a pre-post comparison design, data from pre-DRG's and post-DRG's, the focused geographic area in which we worked, the lack of validity testing on the research instrument, and the limited number of DRG's we were able to analyze.

Nonetheless, we believe that we have substantially accomplished the goals we set for ourselves in addressing the issues and, perhaps more importantly, we have a great deal of enthusiasm in the fact that the tool seems to be very useful beyond the constraints of this individual project.

We studied 2,600 medical charts, 1,300 in the pre-DRG period and 1,300 in the post-DRG period in four hospitals using a random selection of charts from five DRG's: Stroke, pneumonia, heart failure, hip replacement, and major joint pinning.

Our findings, in brief, were that in terms of length of stay or "quicker," that length of stay has in fact declined by an average of 2.7 days in the four hospitals we studied, from 11.3 days overall to 8.6 days overall, with stroke having the greatest reduction of length of stay from 11.4 days to 7.7 days or a 3.7 day reduction.

Additionally and interestingly, the length of stays has become more uniform within DRG's. The degree of variation among patients and length of stay in a DRG category has become more uniform and more consistent.

In terms of the sicker finding, which is really the key point, and again based on our dependency rating in terms of the ability of patients for self-care as the measure of sicker, three of the five DRGs—hip replacement, heart failure, and pneumonia—do show a statistically significant increase in the degree of dependency of the patient at the point of discharge from the hospital. Two of the five—stroke and major joint pinning—did not show significant increases in dependency. Therefore, our data indicates that there are patients being discharged more dependent, that it is DRG specific and varies in degree among DRG's.

As I said, importantly, we think the tool which gathers data from hospital medical records, is highly reliable and convenient to use and can be the basis for broader research areas. It already has been used by the Oregon PRO in a study that it is doing on patient discharge readiness; and we also think it eventually can be a tool for assessing recovery and outcome over time, which I had mentioned previously, is probably the key issue we face.

We need to do more validity testing, and we need to do studies over a larger area and more DRG's; and we plan to do that.

In summary, we think that the discharge planning function is a key function, that a tool that is reliable and easy to use and assesses patient's status can help that function and make it even more uniform, that a tool should use dependency scales such as we have developed to make it worthwhile and to make it comparable.

I appreciate the time and your attention, and I would be more than happy to answer questions.

Senator **Durenberger**. And your full statement will be made part of the record.

Mr. **Goldwyn**. I take that bell very seriously.

Senator **Durenberger**. All right. Thank you very much. Dr. Chassin.

[The prepared written statement Mr. Goldwyn follows:]

TESTIMONY OF

Merilyn Coe, Dr.P.H.
Anne M. Wilkinson, M.S.
Patricia Patterson, R.N., M.A.
Michael R. Goldwyn, M.A.

on

DEPENDENCY AT DISCHARGE: IMPACT OF DRGs

Research Project

Before the Committee on Finance

United States Senate

June 3, 1986

Mr. Chairman and Members of the Committee:

My name is Michael Goldwyn, Executive Director of Northwest Oregon Health System, Portland, Oregon. With me is Merilyn Coe, Dr.P.H., the Principal Investigator of the project and Anne Wilkinson, M.S., Director of Research for NOHS and Project Director on the study. It is a pleasure for us to be here today to report the findings of our research project, "Dependency at Discharge: Impact of DRGs".

In early 1985, Northwest Oregon Health Systems (NOHS), the designated Health Systems Agency, re-evaluated its mission and decided to adopt health policy research as a priority. In response to the rapidly changing health care market, we decided to focus on those areas in the health care system undergoing the most change. In our view, this included two major thrusts:

- assessing the impact of the Medicare Prospective Payment (PPS)/Diagnostic Related Group (DRG) payment system; and
- assessing the impact of competition and cost containment on the poor and indigent.

In relation to the first priority, as you know, the 1983 Social Security Amendments directed the U.S. Department of Health and Human Services (DHHS) to establish a prospective payment system (PPS) for Medicare reimbursement to hospitals. As of October 1, 1983, most short-term general stay hospitals had begun to phase in the new reimbursement system. The amount of the reimbursement is determined by the Diagnosis Related Group (DRG) by which the patient is classified (Federal Register, 1983/1984). Although the new system is highly complex, with 470 DRG classifications, it does reverse the cost-generating incentives inherent in the former cost-based system. By replacing the previous payment system with a fixed payment for each patient discharged, hospitals are faced with a new set of incentives to control resources used in the care of the Medicare patient.

Hospitals have responded quickly to the financing mechanism change. The Office of Technology Assessment reported that three strategies are likely to be implemented by hospitals in their search for per case cost reduction: 1) reducing length of stay; 2) adopting management and staffing efficiencies; and 3) integrating services vertically (OTA, 1985). Indeed, since 1977, the average length of stay in acute care hospitals has been decreasing (Baldwin, 1985) and it is likely that PPS will accelerate this trend.

One possible result of PPS is that Medicare patients may be discharged with higher levels of functional disabilities and with greater need for care from post-hospital providers. A preliminary study in the Portland, Oregon metropolitan area supported this prediction (Murray, 1985). In addition to the increased severity, Friedman (1985) found that a greater number of Medicare patients have been admitted to Oregon nursing homes following the implementation of prospective payment. These reports, along with a considerable amount of anecdotal information about the impacts of PPS on the community health system, were of concern to Northwest Oregon Health Systems and precipitated the effort by NOHS to examine whether Medicare patients are being discharged "quicker and sicker".

Several factors combine to make research into this topic an important objective for NOHS.

- In the Portland area, one response to the PPS methodology has been a reduction in length of stay. The average length of stay for all patients in

Northwest Oregon was 6.0 days in the first quarter of 1983 and 5.19 days in the fourth quarter of 1985.

- Recent reports on conditions in Oregon nursing homes and home care agencies indicate that these programs have had an increased number and proportion of heavy-care patients shifted to them since the implementation of PPS.

- Although most studies on the effects of PPS have been directed to adaptation in the hospital industry (organization and management) little information, locally or nationally, has been obtained about the impact on beneficiaries.

Prior to PPS most discharge decision-making was influenced by a variety of medical and social factors, whereas after PPS, this process has been heavily impacted by new and powerful economic forces. Due to the shift in emphasis, new questions regarding patients status are now being identified.

In response to the question of beneficiary impact and to address local concerns, NOHS initiated a preliminary research activity. Our intent was to establish a statistically valid approach to assessing patient status at hospital discharge before and after the implementation of the DRG/PPS system. The project was initiated in December, 1984 under the direction of Merilyn Coe, Dr.P.H. and Anne Wilkinson, M.S.

The study design required that information on patient status be obtained from hospital medical records. However, no such tool existed. Therefore, in order to address the objective of assessing the impact of DRGs, an instrument had to be designed, pre-tested and refined. This data collection instrument was developed in concert with Patricia Patterson, R.N., M.A. In October, 1985, NOHS was awarded a grant by the Health Care Financing Administration (HCFA) enabling the enlargement of the study.

METHODOLOGY

Instrument Development and Testing

With the implementation of the DRG based PPS, the effort to evaluate management performance, market share, staffing patterns and financial viability has taken precedence over efforts to examine the impact on beneficiaries. The Dependency at Discharge project was designed to develop a methodology for measuring patient dependency from hospital records, to test the "Dependency at Discharge" (DpaD) research instrument, and to apply this instrument to measure changes in patient health status at discharge that may be attributable to the implementation of PPS.

Clearly, the variables forming a patient classification scheme depend on the ultimate use of the care system. Many case mix grouping systems and measures of patient characteristics have been advanced to describe patient populations, their resource consumption, and their impact on the delivery system. For the purpose of admission to an acute care facility, two classification systems are common: DRG and ICDA codes. The major explanatory variable in these systems is medical diagnosis. However, many authorities have pointed out the limitations of a diagnosis-centered approach in decribing the elderly (Kane & Kane, 1984).

The next most utilized set of assessment tools fall into the category of screening or pre-screening tools for post-hospital placement. Some hospital social work departments have developed tools for identifying high risk patients and have developed flagging criteria for tracking patients from the time of admission. However, this approach has been directed primarily towards assessing social, financial and functional status, and excludes medical indicators. The major limitation of these assessment mechanisms is that they are observation based.

Eleanor Chelminsky (1985) claimed, in her statement to the Senate Special Committee on Aging, that "there are no existing, validated measures currently being used to abstract data from medical records except for physical conditions". The standard assessment methodology for hospital record discharge summaries is the "Interqual" which measures patient medical stability. Recognizing the need for a new instrument that would not only synthesize medical and functional variables but be based on secondary information as well, the study team developed the "Dependency at Discharge" instrument during the first phase of the project (December -September, 1985).

Measurement variables were selected that had sufficient documentation and would be common across hospital settings. The literature on patient classification supported using indicators of activities of daily living and indicators of need for nursing service. Building upon this research, the measures selected were: ACTIVITY/MOBILITY and BATHING/HYGIENE. Three measures were selected as indicators of potential nursing need: SIGNS/SYMPTOMS; MEDICATIONS and PROCEDURES. Age was added to the formula because the literature suggests that higher incidence of post-hospital dependency and care requirements is associated with increasingly old age. The initial tool also included psycho/social measures (standard in most placement screenings). However, there was almost no chart documentation for the psycho/social factors.

In addition to the ratings, the study abstracted descriiptive and placement information. Descriptive items included: sex, race, hospital, DRG, admission date, discharge date, readmission date, readmission DRG, rater, review date. Data on pre/post hospital living arrangements and recommended community services were also extracted.

Content validity was established for the tool through literature review, chart content review and expert panel review. The final instrument, developed by Patterson, Coe and Wilkinson, measured the individual level of independence and/or dependence in self-care at the point of hospital discharge. The section on instrument development in our final report describes the instrumentation process in detail.

The purpose of the second phase of the project (October - May) was to test the instrument for reliability and to compare pre to post DRG characteristics. Two types of reliability were addressed to test the "Dependency at Discharge" Instrument: inter-rater and internal consistency. Reliability was measured on a random sample of 162 records from the four hospitals at two month intervals during the data collection process for a total of eleven reliability samplings. Using Pearson Correlation analysis, agreement between pairs of raters (seven data collectors in total) was computed for the six item instrument with a mean of mean coefficients at .92. Further, 93% of the rater pairs obtained coefficients of above .80 for the scale. These findings indicate a high level of agreement for the Dependency scale.

A more stringent test for inter-rater agreement was conducted by calculating mean correlation coefficients for the six items independently. The mean coefficients were: ACTIVITY - .79; BATHING - .82; MEDICATIONS - .75; PROCEDURES - .79; SYMPTOMS - .79; AGE - .99. Agreement was weaker for the individual items than for the DEPENDENCY scale as a whole. The exception was the AGE item, which did not require judgement.

The internal consistency of the instrument was examined by calculating alpha coefficients. This coefficient is a function of both the number of items and the average correlation among items. For the six item scale the Alpha coefficient was .79; for the five item scale (without MEDICATIONS) .82; and for the four item scale (without AGE and MEDICATIONS) .86.

Based on a number of considerations, the four-item scale was chosen for use in this study. In addition to the higher alpha coefficients, two other elements support this decision. The removal of AGE is based on the recognition that age is already factored into the DRG formula. Therefore, if DEPENDENCY is to be considered as a potential DRG formula co-factor, then age should not be represented twice. Also, the removal of age and medications from the scale is supported by the low correlations of the item with the other items.

In summary, it is clear from the reliability analyses, that the DEPENDENCY inter-rater agreement and internal consistency were well above acceptable standards. In particular, DEPENDENCY is highly reliable consisting of the four items: ACTIVITY: BATHING: PROCEDURES: and SYMPTOMS. The Dependency at Discharge research instrument and protocols for data collection were completed in July, 1985.

Data Collection Training (August - September, 1985)

Seven nurses, all baccalaureate level, were hired and trained to use the instrument in two separate training periods. The first group of three data collectors was trained in August, 1985, using records from all study site hospitals. A second group of four data collectors was trained in October, 1985, using charts from one of the study hospitals.

Research Design

The research design is an interrupted time-series design. This approach involves abstracting data from medical records in two time periods. The first period (1981-1983) represents the cost based system; the second (1984-1985) reflects the prospective payment system. The two time periods for chart sample selection were October, 1981 through September, 1983 for the pre-DRG period and March, 1984 through July, 1985 for the post-DRG period. The samples were evenly divided into the two periods.

Four hospitals participated in the study and were similar in organization and type of patient services. Two were large hospitals (300+ beds) and two were medium size (100-300 beds). Their participation was voluntary and confidential.

Sample Selection

In order to assess the medical, as well as the surgical intervention, five diagnostic related groups (3 medicals/2 surgicals) were selected for comparison in the pre/post design based on the frequency of that DRG in the Portland metropolitan area. The groups were:

DRG 14 - Stroke
DRG 89 - Pneumonia
DRG 127 - Heart Failure
DRG 209 - Hip Replacement
DRG 210 - Major Joint Pinning

The sample size was determined by power tables (Fleiss, 1973). In order to test for a result greater than chance (.05), a minimum of 150 observations per DRG per time period was necessary. This would require a minimum of 1,500 charts to be reviewed. Because there were four hospitals participating, we decided to oversample for a desired total of 2,900 charts.

To control for the possible effects of changes in management policies and practices as a result of PPS, data were not collected for admissions six months before and six months after each hospital converted to the DRG reimbursement system (conversion period). Each hospital had different PPS start-up periods but all conversions transpired between October, 1983 and April, 1984. Thus, selected DRG admissions were eligible for inclusion in the study from October, 1981 through July, 1985 except for the period between April, 1983 and September, 1984 when the sample hospitals were converting to the PPS system. The desired sample size is presented below and the study sample closely approximates the desired sample selection.

Desired Sample Selection

	Pre-DRG 10/81 - 9/83	(Conversion)	Post-DRG 4/84 - 7/85	Total
		Medical DRG (14, 89, 127)		
Hospital A	250		250	500
Hospital B	250		250	500
Hospital C	250		250	500
Hospital D	250		250	500
		Surgical DRG (209, 210)		
Hospital B	150		150	300
Hospital C	150		150	300
Hospital D	150		150	300
				2,900

Hospital records were randomly selected for inclusion from master lists of DRG-specific Medicare admissions supplied by the study hospitals for the pre and post time periods. Inclusion on the masterlist of Medicare admissions depended upon the following criteria: Medicare beneficiary, 60 years or older, discharge date, and was discharged under the study's selected diagnostic related groups (DRGs) - 14, 89, 127, 209 and 210. Generally, the masterlist included the following information for each admission: patient identification number, admit date, discharge date, length of stay, and DRG.

The study sample was randomly selected from each hospital's masterlist according to the following criteria: Age (60 or older), did not expire on selected admission, and a length of stay between two (2) days and twenty-two (22) days. Lists of eligible medical records for each hospital were then typed and given to the hospitals to use in selecting patient records. The NOHS data collectors also used this list to mark off each chart when it had been abstracted.

Data Collection

Data abstraction for the study sample took place between September, 1985 and April, 1986. Ms. Wilkinson coordinated the scheduling of data collection with each of the medical records directors. In consideration of the work load of the hospital records departments and the demands of this project (e.g., approximately 800 charts per hospital), all data collection activities were scheduled at least a week in advance. In addition, the hospitals required from three days to one week for pulling selected sample records. Data collection in each hospital lasted from two to three months.

A total of 2,622 records were abstracted in this study; 593 from Hospital A, 648 from Hospital B, 509 from Hospital C, and 735 from Hospital D. Completion rates for data collection were extremely high with only five (5) charts from the entire sample being ineligible due to insufficient data in the medical record. A few charts were determined to be ineligible for other reasons, including: the patient expired on the identified admission; the chart could not be found or was being used on the floor for other purposes; the chart was out of the hospital being transferred to microfiche; the wrong identification number was typed on the list and the appropriate chart could not be identified; the length of stay was shorter or longer than the two to twenty-two days stay; or the DRG was wrong. Where there were replacements available, ineligible charts were supplemented until a minimum of 80 charts per DRG were coded or no other charts were available. In two hospitals, the universe of cases did not equal or exceed the minimum of cases per DRG, per time period. Where possible, over-sampling was done for the pre and post time periods to ensure an adequate pool of replacement cases for charts found to be ineligible. The data was reasonably complete with no single variable having more than one percent (1%) missing data. A detailed description of the data collection process can be found in our final report.

DATA ANALYSIS

The objective of the data analysis was to examine and test the differences in pre/post characteristics. The section is divided into six areas: descriptive information; length of stay; distribution by age and DRG; Dependency by DRG; Dependency by age; and Dependency class.

Descriptive Information

All record subjects were Medicare beneficiaries; 36% male; 64% female. The sample of 2,622 charts included 1,264 (48%) in pre and 1,358 (52%) in post. The distribution by DRG was:

DRG	TOTAL	PRE	POST
Stroke (14)	632 (24.2%)	295 (46.7%)	337 (53.3%)
Pneumonia (89)	630 (24.1%)	289 (45.9%)	341 (54.1%)
Heart Failure (127)	733 (28.0%)	351 (47.9%)	382 (52.1%)
Hip Replacement (209)	371 (14.2%)	180 (48.5%)	191 (51.5%)
Major Joint Pinning (210)	248 (9.5%)	141 (56.9%)	107 (43.1%)
Total	100 %		

A Chi square test indicated that the samples were not significantly different based on distribution of DRG.

Length of Stay (LOS)

The measurement of LOS was constrained by the sampling methodology. We included only those LOS between two and twenty-two days in order to limit the outlier effect. The mean LOS for the five diagnostic groups, in pre was 11.3 days and in post was 8.6 days. This represents a significant reduction of 2.7 days.

When LOS is examined by the differences between medical and surgical, the medical DRGs (14, 89, 127) had far more variance (as measured by standard deviation) than surgical DRGs (209, 210). In addition, when LOS is computed by DRG by year (pre/post), there was a significant reduction in LOS in all DRGs. Data on length of stay analysis is presented in Table 1.

TABLE 1

SUMMARY OF LENGTH OF STAY

	(N=2,528)	Mean Days	Standard Deviation	t-value
TOTAL	PRE (1,208)	11.3	4.9	
	POST (1,320)	8.6	3.8	15.01***

LENGTH OF STAY BY DRG BY PRE/POST

DRG 14	(Stroke)	Mean Days	Standard Deviation	t-values
	PRE (277)	11.4	5.3	
	POST (327)	7.7	3.3	10.10***
DRG 89	(Pneumonia)			
	PRE (276)	9.6	4.3	
	POST (336)	7.8	3.5	5.16***
DRG 127	(Heart Failure)			
	PRE (336)	9.2	4.7	
	POST (372)	7.2	3.1	6.67***
DRG 209	(Hip Replacement)			
	PRE (177)	15.5	3.6	
	POST (189)	12.3	3.6	8.27***
DRG 210	(Major Joint Pinning)			
	PRE (134)	13.8	4.3	
	POST (104)	11.5	3.8	4.45***

***p<.001

Age

One of the most interesting findings is the drop in the average age of the sample between the Pre and Post periods. The average age for the Pre period was 80.3 years and for the Post period 77.2 years. Rather than using age as a continuous variable, it was grouped into four age categories; 60-65, 66-75, 76-85 and 86+. The distribution by percent of the total sample was:

Age Category	PRE (n=1228)	POST (n=1329)	Total (n=2557)
60-65	2.4%	6.2%	4.1%
66-75	24.5%	27.6%	26.1%
76-85	39.5%	40.5%	40.4%
85+	33.4%	25.7%	29.4%

Chi square test = $p < .002$

By disaggregating and comparing Age by DRG, an interesting pattern is evident.

TABLE 2

AGE DISTRIBUTION BY PRE/POST AND DRG

Stroke	PRE (n=285)	POST (n=328)	Total
60-65	1.8%	3.0%	2.4%
66-75	20.7%	30.2%	25.8%
76-85	44.2%	45.4%	44.9%
86+	33.3%	21.3%	26.9%

Pneumonia	PRE (n=278)	POST (n=331)	Total
60-65	2.2%	8.2%	5.4%
66-75	26.3%	23.0%	24.5%
76-85	35.6%	33.2%	34.3%
86+	36.0%	35.6%	35.8%

Heart Failure	PRE (n=345)	POST (n=372)	Total
60-65	1.2%	3.5%	2.4%
66-75	20.3%	29.3%	25.0%
76-85	41.4%	41.7%	41.6%
86+	37.1%	25.5%	31.1%

Hip Replacement	PRE (n=180)	POST (n=191)	Total
60-65	6.7%	9.9%	8.4%
66-75	36.7%	34.0%	35.3%
76-85	35.6%	46.1%	41.0%
86+	21.1%	9.9%	15.4%

Major Joint Pinning	PRE (n=140)	POST (n=107)	Total
60-65	2.1%	6.5%	4.0%
66-75	23.6%	16.8%	20.6%
76-85	39.3%	39.3%	39.3%
86+	35.0%	37.4%	36.0%

*Chi square method, the difference is significant.

There was a significant increase in the younger Age groups (60-85 years) for stroke, heart failure and hip replacement patients and a corresponding decrease in the 86+ Age group (See Table 2). No such pattern was seen for pneumonia and major joint pinning. These two DRGs represent 41% of the admission in the 86+ Age sample. If older patients are not being admitted in certain DRGs, what factors are influencing this trend? Five health system changes between Pre and Post might be contributory:

1. More stringent admissions criteria (e.g. higher acuity)
2. Coding different (20% of the Pre sample were coded on ICD-A codes versus DRGs);
3. Upgrading of nursing homes - capacity to handle older stroke or heart failure patients who are having a subsequent episode;
4. Expansion of technological capacity (e.g., incentive to perform hip replacements at younger age);
5. Competition.

While more stringent admission criteria might apply across all DRGs, the issue of technological capacity does not. For example, our findings showed that patients who had hip replacements were significantly younger in the post-DRG period while at the same time, the Age distribution of patients receiving major joint pinning were proportionately equal in both the pre and post time periods.

In comparing the three medical DRGs (stroke, pneumonia, heart failure), it is possible that the difference between the need for medical management, as opposed to nursing management, may account for older stroke and heart failure patients being cared for in nursing homes rather than being sent to hospitals. Pneumonia patients are, perhaps, being sent to hospitals because of the need for medical intervention.

Dependency by DRG

The DEPENDENCY SCALE that measured Dependency at the point of hospital discharge used four items: ACTIVITY, BATHING, PROCEDURES and SYMPTOMS. The scale ranges from 0 to 24. The overall average dependency for pre was 8.9 and for post was 9.7. Applying a t-test, the difference is significant at the .001 level (Table 3). In some instances, this difference may not have a great pragmatic value, but the instrument appears to be sensitive enough to detect small changes that could be important intrinsically or could grow over time. The scale also provides a baseline from which to measure the effects of post-hospital sub-acute care and provide a mechanism for analyzing readiness for discharge.

Disaggregating the total is necessary to understand the differential impact of PPS on the five DRGs (Table 3). Three out of five pre/post tests, based on individual DRGs, were significant. The three DRGs in which the data indicate a significant increase in dependency are hip replacement (.001), heart failure (.01) and pneumonia (.05). The data did not indicate a significant increase in dependency in stroke and major joint pinning. Major joint pinning showed high dependency for both the pre and post periods and suggests that the technology for major joint pinning has remained constant.

TABLE 3

DEPENDENCY SCORES
By Pre/Post and By Pre/Post By DRG

Overall Dependency By Year

	PRE	POST	t-value
	8.9	9.7	3.79***

Dependency By Year By DRG

	PRE	POST	t-value
Stroke	11.2	12.3	1.89
Pneumonia	7.9	8.9	1.99*
Heart Failure	6.5	7.5	2.53**
Hip Replacement	7.9	9.4	4.01***
Major Joint Pinning	12.3	12.4	.22

* $p < .05$
** $p < .01$
*** $p < .001$

Dependency Classification

In order to provide a more useful assessment framework, we decided to reduce the DEPENDENCY SCALE into four classes. These classes were:

Class I	0-5	:	minimally dependent
Class II	6-11	:	somewhat dependent
Class III	12-17	:	moderately dependent
Class IV	18-24	:	severely dependent

As can be seen in Table 4, in the post period, the proportion of Class I decreased while the proportions in all other classes of dependency increased. As tested by chi square, the difference between pre and post was significant at the .001 level.

TABLE 4
DISTRIBUTION OF SAMPLE BY DEPENDENCY CLASS

	PRE (n=1256)	POST (n=1358)	Total (n=2614)
Class I	28.7	22.5	25.5
Class II	42.8	44.5	43.5
Class III	15.1	17.5	16.4
Class IV	13.3	15.8	14.6
Total	100. %	100. %	100. %

Chi square test = $p < .001$

SUMMARY AND FUTURE PLANS

This section summarizes the results of the "Dependency at Discharge" study. The "Dependency at Discharge" instrument was based on criteria relevant to the hospitalized population. The scale was composed of items identified from a literature review and data available on patient hospital charts. The reliability results were very positive. Not only was the instrument convenient and reliable but it supported the use of secondary data for classifying patients. Based on the successful reliability results, as well as the tool's convenience for measurement of hospital records in lieu of direct patient observations, we believe the instrument warrants additional development; specifically, validity testing.

The findings are circumscribed by the lack of validity testing on the instrument, the inherent fallability of any pre/post design as well as the limited geographical sampling. Potentially, there are many factors that could confound the results. We tested one; Age, and found the two samples to be significantly different. We could have tested other demographic characteristics, economic climate (i.e., degree of competition) or technological shifts.

Of major interest is the age difference between the Pre-DRG sample and the Post-DRG sample. The Post sample was significantly younger (and significantly more dependent in certain DRGs). One explanation for this phenomenon is that the old, old are not being admitted to hospitals unless they display acute medical symptoms. We hypothesize that they remain in other settings such as nursing homes and homes, whereas in pre-DRG years they would have been admitted to a hospital. Therefore, the older old may be remaining in these other settings for those diagnoses that center on nursing intervention rather than medical treatment.

In addition to the change in age distribution toward the younger beneficiary, Dependency score increased in three of the five DRGs studied : pneumonia, heart failure and hip replacement. When considering these findings, it appears that the cost containment system is indeed having an impact on individual health status among patients in certain DRG classes. Whether this increased dependency influences the ability for the patient to recuperate in other settings could not be examined in this pilot study. Replication studies are needed before generalizing the findings to other DRGs.

Policy Implications

The first implication derived from this study is that discharge decision-making should incorporate a systematic approach for screening patients in preparation for hospital discharge. Further, we suggest that the screening method include a measure of patient Dependency, as defined in this study. Our evidence suggests that self-care limitations can be reliably estimated by rating nobility, bathing, care procedures and symptoms. The cluster of these parameters enables a more discriminating assessment than do any of the individual elements. Eventually this approach could enable a more appropriate match between patient needs and continuing care resources.

A second policy implication concerns progressive differences in the health care system configuration. The focus of hospitals has evolved from a broad scope of health disability care to a narrow scope of strictly defined acute medical care. Hospitals are realizing cost savings due to reduced length of stays but patients are leaving the hospital in a more dependent state in certain DRGs. The inference here is we may need to re-examine the concept of continuity of care to ensure that post-hospital care facilities and agencies are adequately equipped, financed and prepared to accommodate this shift. Quality care standards should not be dependent on setting. We recognize the need for care review and strongly support the development of post-hospital care policy which will enable adequate services for Medicare beneficiaries.

In conclusion, we believe that future work should include investigations pertaining to Dependency in: other representative DRGs; in other hospital settings; in other regions of the country; and in other health care delivery settings, such as nursing homes, group homes and private homes. NOHS is committted to continuing this important research so that we can better understand the impact of policy on the health status of a significant portion of our population.

This concludes our prepared statement. We will be happy to answer any questions the Committee may have.

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FINAL REPORT

on the

DEPENDENCY AT DISCHARGE STUDY

by

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The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Health Care Financing Administration. The contractor assumes responsibility for the accuracy and completeness of the information contained in this report.

I. EXECUTIVE SUMMARY

Purpose:

The 1983 Social Security Amendments directed the U.S. Department of Health and Human Services (DHHS) to establish a prospective payment system for Medicare reimbursement of hospitals. As of October 1, 1983, most short-term general stay hospitals began to phase-in the new prospective payment system (PPS). The amount of reimbursement is determined by the Diagnosis Related Group (DRG) by which the patient is classified (Federal Register, 1983/1984). The new DRG system is highly complex with 470 classifications, but it does reverse the cost-generating incentives inherent in the former retrospective, cost-based reimbursement system. By replacing the previous payment system with a fixed payment for each patient discharged, hospitals are faced with a new set of incentives to control resources provided to the Medicare patient.

Hospitals are responding quickly to the change in the financing mechanism. The Office of Technology Assessment reported that three strategies are likely to be implemented by hospitals in their search for per case cost reduction: 1) reducing length of stay; 2) adopting management and staffing efficiencies; and 3) integrating services vertically (OTA, 1985). Indeed, since 1977, the average length of stay in acute care hospitals has been decreasing (Baldwin, 1985). It is probable that PPS will accelerate this trend and one possibility is that Medicare patients may be discharged with higher levels of functional disabilities and with greater need for medical and other care from post-hospital providers. A preliminary study in the Portland, Oregon metropolitan area supported this prediction (Murray, 1984). In addition to these patients requiring more skilled care, Friedman (1984) found that a greater number of Medicare patients have been admitted to Oregon nursing homes following the implementation of prospective payment. The findings of these studies, along with a number of PPS-impact anecdotes from nursing homes, home-care agencies and the public, have been of concern to the local health planning agency, Northwest Oregon Health Systems (NOHS).

Several factors combine to make research into this topic an important objective for NOHS.

* In the Portland area, one response to the PPS methodology has been a reduction in length of stay. The average length of stay for all patients in Northwest Oregon was 6.0 days in the first quarter of 1983 compared to 5.19 days in the fourth quarter of 1985.

* Recent reports on conditions in Oregon nursing homes and home care agencies indicate that these programs have had an increased number and proportion of heavy-care patients shifted to them since the implementation of PPS.

* Although most studies on the effects of PPS have been directed to hospital industry adaptation (organization and management) little information has been obtained either locally or nationally about the impact on beneficiaries.

To address the question of beneficiary impact, NOHS initiated a preliminary research activity. The result of this work was the design of an instrument "Dependency at Discharge" which measures self-care dependency at the time of hospital discharge. The developers were Patty Patterson, R.N., M.A.; Merilyn Coe, Dr.P.H.; and Anne Wilkinson, M.S.

Objectives of this Project

The Dependency at Discharge Study, which is reported here, was designed to continue to test the "Dependency at Discharge" instrument, and to measure changes in discharge health status that may be attributable to the implementation of PPS.

Research Design

The research design was an interrupted time-series design. This approach involved abstracting data from medical records in two time periods. The first period in the study represented cost-based reimbursement; the second reflected the prospective payment system. To address the question of differences in discharge health status, 2,622 charts were randomly selected in five diagnostic categories from four Portland hospitals. The two time periods for chart sample selection were October, 1981 through September, 1983 for the pre-DRG period and March, 1984 through July, 1985 for the post-DRG period. The samples were evenly divided into the two periods.

The literature on classification and assessment of patient status generally supports the idea that the critical factors which characterize patient needs at hospital discharge are functional dependency and physiological stability. Our instrument "Dependency at Discharge" is an acuity rating scale that measured Dependency using six items: activity; bathing; medications; procedures; symptoms; and age. Following reliability testing, two items (medication and age) were deleted and data in the sample were analyzed based on a four-item scale. All data were abstracted from medical records.

To acknowledge the medical as well as the surgical intervention, five diagnostic related groups (DRGs: 3 medicals/2 surgicals) were selected for comparison in the pre/post design. The groups were:

DRG 14 - Stroke
DRG 89 - Pneumonia
DRG 127 - Heart Failure
DRG 209 - Hip Replacement
DRG 210 - Major Joint Pinning

Four hospitals participated in the study and were similar in organization and type of patient services. Two were large hospitals (300+ beds) and two were medium size (100-300 beds). Their participation was voluntary and confidential.

Other Studies

Several other agencies are supporting research studies to assess the PPS impact on quality of care. For example, HCFA has funded Rand Corporation, CPHA, The Urban Institute, as well as a number of PROs across the country. In addition, ProPAC, the Prospective Payment Assessment Commission, has contracted with Health Economics Research, Incorporated for a comprehensive research plan on quality of care. We feel that our study will compliment these larger and longer studies.

Summary of Major Findings:

A. Dependency Scale Reliability Testing
    1. Inter-item reliability: Alpha Coefficient = .86
    2. Average inter-rater reliability (r) = .92
    3. Item completion = 98%

B. Pre/Post Analysis
    1. Significant difference in length of stay
    2. Significant difference in age
    3. Significant difference in dependency in select DRGs

C. Discharge Disposition
    1. Distinct difference in pattern of post-hospital placement between 1982 and 1984
    2. An increase in home health referrals in 1984.

Limitations

Although the sample is large, the investigators advise caution in interpreting the results because of the limited instrument testing and the singular geographic sampling. While it is possible that there are regional variances in charting practices, the National Joint Commission on Accreditation of Hospitals requires a fairly uniform standard; therefore, we expect that documentation is available in most hospital records.

Need For Additional Research

Based on the successful reliability results, as well as the instrument's convenience for measurement of hospital records in lieu of direct patient observations, the investigators believe the instrument warrants additional development. Further testing of the instrument to measure concurrent validity, criterion-related validity and predictive validity are the logical and necessary next steps. Replication studies are needed in other DRGs.

II. ACKNOWLEDGEMENTS

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III. INTRODUCTION

The 1983 Social Security Amendments directed the U.S. Department of Health and Human Services (HHS) to establish a prospective payment system for Medicare reimbursement to hospitals. As of October 1, 1983, most short-term general stay hospitals had begun to phase-in the new reimbursement system (PPS). The amount of the reimbursement is determined by the Diagnosis Related Group (DRG) by which the patient is classified (Federal Register, 1983/1984). The new system is highly complex with 470 DRG classifications, but it does reverse the cost-generating incentives inherent in the former retrospective, cost-based system. By replacing the previous payment system with a fixed payment for each patient discharged, hospitals are faced with a new set of incentives to control resources used in the care of the Medicare patient.

Hospitals have responded quickly to the financing mechanism change. The Office of Technology Assessment reported that three strategies are likely to be implemented by hospitals in their search for per case cost reduction: 1) reducing length of stay; 2) adopting management and staffing efficiencies; and 3) integrating services vertically (OTA, 1985). Indeed, since 1977, the average length of stay in acute care hospitals has been decreasing (Baldwin, 1985). It is likely that PPS will accelerate this trend, which precipitated the inquiry of whether Medicare patients are being discharged quicker and sicker (GAO, 1985).

One possibility is that Medicare patients may be discharged with higher levels of functional disabilities and with greater need for care from post hospital providers. A preliminary study in the Portland, Oregon metropolitan area supported this prediction (Murray, 1985). In addition to the increased severity, Friedman (1985) found a greater number of Medicare patients have been admitted to Oregon nursing homes following the implementation of prospective payment. These reports, along with a considerable number of anecdotal statements, were of concern to the local health planning agency, Northwest Oregon Health Systems (NOHS).

In response to these local issues, NOHS funded a small research project to examine the health status of Medicare patients at hospital discharge before and after the implementation of PPS. The project was initiated under the direction of Merilyn Coe, Dr.P.H. and Anne Wilkinson, M.S. The data collection instrument was developed in concert with Patricia Patterson, R.N., M.A. In October, 1985, NOHS was awarded a grant from the Health Care Financing Administration (HCFA), which enabled us to conduct the study described in this report "Dependency at Discharge".

Many case mix grouping systems and measures of patient characteristics have been advanced to describe patient populations, their resource consumption, and their impact on the delivery system. However, with the implementation of the DRG based PPS, the effort to evaluate its impact has been focused on a few hospital related issues. For instance, the considerable research done on management performance, market share, staffing patterns, and financial viability has taken precedence over efforts to examine the impact of the PPS methodology on beneficiaries.

Clearly, the variables forming a patient classification scheme depend on the ultimate use of the care system. For the purpose of admission to an acute care facility, two classification systems are common: DRG and ICDA codes. The major explanatory variable in these systems is medical diagnosis. However, many authorities have pointed out the limitations of a diagnosis-centered approach in describing the elderly (Kane & Kane, 1984). Recently Susan Horn (1986) reported that information based solely on diagnosis, expenses or charges makes clinical comparison difficult.

The next most utilized set of classification tools falls into the category of screening or pre-screening tools for post-hospital placement. Some hospital social work departments have developed tools for identifying high risk patients and have developed flagging criteria for tracking patients from the time of admission. However, their approach has been directed primarily towards assessing social, financial and functional status excluding medical indicators.

The scope of the original NOHS study required that the data collection process be based on chart review. Eleanor Chelminsky (1985) asserted in her statement to the Senate Special Committee on Aging that "there are no existing, validated measures currently being used to abstract data from medical records except for physical conditions". The standard assessment methodology for hospital record discharge summaries is the "Interqual" which measures patient medical stability.

Indeed, there is a need for a multi-dimensional instrument that would include several variables. We determined that this was a necessary step and decided to begin by examining the content of nursing notes for information on functional status. The Dependency at Discharge classification tool builds upon this perspective and includes ratings on nursing requirements (procedures, signs/symptoms, medications) as well as three factors often found in placement screening tools (activity/mobility, bathing and psycho/social status). In addition to the ratings, other information was collected. Descriptive items were: sex, race, hospital, DRG, admission date, discharge date, readmission date, readmission DRG, rater and review date. Data were also collected on pre/post hospital living arrangements and community services.

This approach was successful and a prototype of the instrument was developed in March, 1985. The section on Instrument Development details the process. Our research has been a continuous process although it was funded by different agencies at different stages. Initial funding, January to September, 1985, was provided by NOHS and further funding by a HCFA grant was from October, 1985 to May, 1986.

The research team has been able to meet the objectives of the scope of work described in the grant. It appears that the Dependency at Discharge tool is a promising approach to utilizing information in medical charts and to understanding the role of functional disability in classifying patients at the time of hospital discharge.

IV. DISCUSSION

A. METHODOLOGY

1. Instrument Development

Patient classification for purposes of planning and designating resources and dollars has been widely discussed in the literature over the past two decades. Most classification schemes have attempted to quantify the level of nursing care requirements of patients in acute hospital settings. These systems usually include: patient's need for assistance with activities of daily living (ADL); special procedures and treatments; observational needs; instructional needs; and emotional needs. Age has been considered a less universal predictor of nursing care (Giovanetti, 1978). Foley and Schneider (1980) examined six assessment tools for long term care placement and found that most of them related to patient ability to perform ADL, mobility, mental and behavioral status, and degree of nursing services and treatments needed. Leatt, Bay and Stinson (1981) reviewed some 34 classification scales and studies and derived an instrument for assessing and classifying long-term care patients by type of care. They observed 585 patients using 130 measurement variables. They found that the two most important variables for discriminating between care needs were: requirements for nursing services within an institution; and need for medical assessments. The next most important variables were: level of independence in walking; age; and independence in grooming. Their analyses showed that psychosocial variables did not emerge as important contributors for determining care requirements. Brill et al (1978) also found that a patient's level of functioning was more predictive than his diagnostic category for predicting agency resource use.

Another issue is the data collection method used for classifying patients. Most such classification tools depend on direct observations of patients. Ballard and McNamara (1982) reported a retrospective study of 397 records among nine home health agencies within two diagnostic categories (cancer and cardiac). They found that a major limitation was variation in recording systems among the nine agencies and suggested that the lack of standardized recording practices and policies reduced the validity of comparisons between agencies. However, the study was useful as it demonstrated findings similar to those noted above; that is, the critical predictors of nursing care resource use were deficits in self-care and physiological maintenance. The study was also valuable because it explored the use of secondary data for classifying nursing needs and patient status. No other chart review tools could be located from the literature review. This was a strong indication that the present study should be pursued.

Because the instrument was to be used for chart review, it was based on criteria relevant to the hospitalized population and variables were selected that would be common across hospital settings. The literature supported using indicators of activities of daily living and indicators of need for nursing service. The measures selected for activities of daily living were activity/mobility and bathing/hygiene. Three measures were selected as indicators of potential nursing need: signs/symptoms, medications and procedures. In addition, age was added to the formula because it is felt that a higher incidence of post-hospital dependency and care requirement is associated with increasingly older age.

The purpose of the initial Instrument Development phase (March - September) was to develop a tool that would measure an individual's level of independence and/or dependence in self-care at the point of hospital discharge. Through the processes of literature review, chart content review, and expert panel review, content validity was established for the tool. The instrument was developed by Patterson, Coe and Wilkinson. The purpose of the second phase (October - May) was to test the instrument. Reliability was measured using Pearson Correlation analysis. Inter-rater correlation means were compared for the total scale and for each item in 11 reliability test samplings. Frequency distributions of paired correlations were also examined for the six items and for the DEPENDENCY SCALE to determine whether any rater was inconsistent with the others. The study methods and outcomes are described below. Copies of the instrument and the instrument protocols are in the Appendix.

Content Review of Hospital Records (April - June, 1985)

To determine measurability of these variables, 48 records were screened for content availability. A tool containing items borrowed from other patient assessment instruments (relative to activities of daily living and to psychosocial status) and new items (relative to medications, symptoms, procedures) was used to review records from five hospitals. This effort revealed that the desired information was indeed documented in the medical records: activity/mobility (96% of cases); bathing (72%); medications (100%); and symptoms/procedures (87%), as observed by Dr. Coe and Ms. Wilkinson.

A model for the instrument was then designed, using ordinal rating scales and cumulative scoring to achieve an overall classification rating for the patient's level of dependency, or acuity at hospital discharge. The model is similar to many patient classification tools and is structurally similar to the APACHE II severity of illness system for rating critical care patients (Knaus, Draper and Wagner, 1984).

Using the new instrument with six rating scales, a pilot test was conducted on ten hospital records. This test demonstrated that it was possible to use hospital records to rate each patient. Protocols were then drafted to outline decision-making steps for forming judgements about the ratings.

Expert Panel Content Validation (June, 1985)

A group of nurses considered experts in hospital patient assessment for purposes of discharge planning were convened to evaluate the instrument and protocols. The group included two hospital discharge planners, one home health director of a hospital agency, one adult care clinical specialist/nurse educator, and one hospital medical unit head nurse. The evaluation process consisted of a series of independent assessments and votes in answer to the following questions:

1. do the six items pertain to dependency at hospital discharge?
2. are there other items you would add to the concept of dependency at hospital discharge?
3. do the descriptions for the ratings generally pertain to (are they variations of) each tool item?
4. using the definition for each item, are each of the ratings discreet and independent?
5. using the definition and the protocol for each item, are the ratings discreet and independent?

Modifications suggested by the group were incorporated into the instrument and protocol revisions. The Dependency at Discharge research instrument and protocols for data collection were completed in July, 1985.

Data Collection Training (August - September, 1985)

Seven nurses were hired and trained to use the instrument in two separate training periods. The first group of three data collectors was trained in August, 1985, using records from four study-site hospitals. A second group of four data collectors was trained in October, 1985, using charts from one of the study hospitals.

The format for the training sessions was the same for both sessions: the groups assembled for several hours in a conference room near the medical records area. Ms. Patterson, who had written the data collection protocols, served as trainer. In addition, she served as a data collector for the project in each of the four sample hospitals.

The training sessions included reviewing the history and purpose of the Dependency at Discharge research tool, reviewing the data abstraction protocols, and using several trial records for rating and discussion. Agreement rates, based on DEPENDENCY classification, were tallied during the sessions to monitor learning and achievement of consistency across raters. When agreement rates reached at least 70 percent, raters were asked to independently review records for the reliability samplings.

The data collectors were all baccalaureate-level nurses from various schools and with various levels and types of nursing experience. One was recently retired from 40 years work as a medical-surgical nurse, two were recent graduates, two were nursing graduate students and one was a university faculty member. An eighth nurse began the training and the data collection process in August, but soon moved out of the state. Any records she had abstracted for the study were excluded from the data analysis.

2. Instrument Testing

This section describes the activities that occurred upon receiving the HCFA grant. Two types of reliability were addressed to test the "Dependency at Discharge" Instrument: inter-rater and internal consistency. The scale was designed with six items. Other possibilities included using the scale without MEDICATIONS or without MEDICATIONS and AGE. We withheld judgement on which scale was the most parsimonious until reliability analysis could be done.

For the reliability tests, a random sample of 162 records was selected from the four study hospitals. An attempt was made to parallel the study sample by selecting at least three charts per DRG, per pre- or post-time, and per hospital. The reliability sampling was done eleven times, roughly two times per month, during the data collection period. This sample approximates the study sample with representation of DRGs, hospitals, raters, pre-DRG admissions and post-DRG admissions (Table 1).

For inter-rater reliability, we measured agreement between pairs of raters. Since there were seven raters, numerous pairs were subject to testing, using the Pearson correlation statistic. The goal was to achieve correlation coefficients greater than .70. Mean correlation coefficients for paired ratings in each of the eleven samplings were computed for six instrument items and the DEPENDENCY scale (Table 2). The mean of mean coefficients was .92 for DEPENDENCY. Further, 93% of the rater pairs obtained coefficients above .80 for the scale. These findings indicate a high level of agreement for the DEPENDENCY scale, using six items.

A more stringent test for inter-rater agreement was conducted by calculating mean correlation coefficients for the six items independently. The mean coefficients were: ACTIVITY - .79; BATHING - .82; MEDICATIONS - .75; PROCEDURES - .79; SYMPTOMS - .79; AGE - .99 (Table 2). Agreement was weaker for the individual items than for the DEPENDENCY scale as a whole. The exception was the AGE item, which did not require judgement.

The internal consistency of the instrument was examined by calculating Alpha coefficients. This coefficient is a function of both the number of items and the average correlation among items. For the six item scale the Alpha coefficient was .79; for the five item scale (without MEDICATIONS), .82; and for the four item scale, (without AGE and MEDICATIONS) .86.

Based on a number of considerations, the four-item scale was chosen for use in this study. In addition to the higher alpha coefficient, two other elements support this decision. The removal of AGE is based on the recognition that age is already factored into the DRG formula. Therefore, if DEPENDENCY is to be considered as a potential DRG formula co-factor, then age should not be represented twice. Also, the removal of AGE and MEDICATIONS from the scale is supported by the low correlations of these items with the other items (Table 3).

In summary, it is clear from the analyses that the inter-rater agreement and internal consistency were well above acceptable standards. In particular, DEPENDENCY is highly reliable when consisting of the following four items: ACTIVITY; BATHING; PROCEDURES; and SYMPTOMS.

3. Study Design

The second objective of the study was to analyze preliminary evidence on the impact of DRGs using a pre/post design. To accomplish this objective, we sampled charts in 1981, 1982 and 1983, representing the cost-based reimbursement system, and 1984 and 1985, representing the prospective pricing system, thereby employing an interrupted time series design (Campbell and Stanley, 1963). This approach used 18 months of pre-PPS and up to 18 months of post-PPS data on Medicare beneficiaries to develop preliminary evidence of the differences between patient status before and after the implementation of PPS. All charts were randomly selected.

The two time periods were October, 1981 through September, 1983 for pre-DRG and April, 1984 through July, 1985, for post-DRG.

Beginning in October, 1985, the study team made a basic decision about the course of the research. Because of the limited resources, the team decided that only five diagnostic categories could be investigated. The process for determining the selection was complex.

Meetings were set at each of the participating hospitals in order to identify which DRGs were most common and which were problematic (in terms of placement and reimbursement) for that hospital. In addition, the Oregon Medical Professional Review Organization (OMPRO) developed a list of the most common DRGs in the greater Portland area. The lists were then compared, eliminating those DRGs that would identify the hospitals. The top three in all cases were: 14 -stroke; 89 - pneumonia; and 127 - heart failure. There was more variance with the problematic DRGs, but 209 - hip replacement and 210 -major joint pinning were the ones most frequently identified.

The sample size was determined by power tables (Fleiss, 1973). In order to test for a result greater than chance (.05), a minimum of 150 observations per DRG, per time period was necessary. Because four hospitals were participating, we decided to oversample for a desired total of 2,900 charts. Selection for medical DRGs were done in four hospitals and selection of surgical DRGs were done in three hospitals. The desired distribution is illustrated below.

Desired Sample Selection

	Pre-DRG 10/81 - 9/83	Post-DRG 4/84 - 7/85	Total
	Medical DRG (14, 89, 127)		
Hospital A	250	250	500
Hospital B	250	250	500
Hospital C	250	250	500
Hospital D	250	250	500
	Surgical DRG (209, 210)		
Hospital B	150	150	300
Hospital C	150	150	300
Hospital D	150	150	300
			2,900

We were successful in approximating the desired sample selection. Due to various problems (delineated in the next sections) we were only able to review 2,622 charts. An illustration comparing desired sample to actual sample is presented in Table 4.

4. Sample Selection

To ensure a large enough pool of Medicare admissions within the pre/post time periods, the research team determined that only large or medium sized hospitals were eligible for inclusion in the study. Therefore, hospital administrators representing twelve hospitals in the Portland metropolitan area were contacted by letter or by phone and asked for their hospital's participation in the Dependency at Discharge research project. Four metropolitan hospitals, similar in organizational structure and type of patient services, agreed to participate in the study. Two of the hospitals were large (300+ beds) and two were medium sized (100-300 beds). The proportion of Medicare admissions to these hospitals ranged from 20 percent to 65 percent.

The research team met with the numerous review committees in the hospitals to describe the project in greater detail. Meetings were held with each of the hospital's medical records department administrators to make arrangements for data collection. Upon review of the data collection instrument, most of the reviewers and records department administrators believed that the information would be available in their hospital records. Information was gathered about each hospital's record keeping system, and a time was set up to conduct an initial training session for the data collectors. It was important that the data collectors were familiar with the idiosyncrasies of each hospital's record system.

To control for possible effects of changes in management policies and practices as a result of PPS, medical records were not included for the study in the six months before and six months after each hospital converted to the DRG reimbursement system. Each hospital had different PPS start-up periods but all conversions transpired between October, 1983 and April, 1984. Thus, selected DRG admissions were eligible for inclusion in the study from October, 1981 through July, 1985, except for the period between April, 1983 and September, 1984 when the sample hospitals were converting to the PPS system.

Hospital records were randomly selected for inclusion from master lists of DRG-specific Medicare admissions for the pre- and post-time periods. Each hospital's medical records director was asked to supply the research team with lists of all admissions for Medicare beneficiaries two years before and up to 18 months after conversion to the DRG reimbursement system. Inclusion on the masterlist of Medicare admissions depended upon the following criteria: Medicare beneficiary, 60 years or older, discharge date, and discharge under the study's selected diagnostic related groups (DRGs) - 14, 89, 127, 209 and 210. Generally, the master list included the following information for each admission: patient identification number, admit date, discharge date, length of stay, discharge disposition and DRG.

The study sample was randomly selected from each hospital's master list according to the following criteria: age (60 or older), did not expire on selected admission, and a length of stay between two (2) days and twenty-two (22) days. Lists of eligible medical records for each hospital were then typed and given to the hospitals to use in selecting patient records. The NOHS data collectors also used this list to mark off each chart when it had been abstracted. The minimum number of charts, per hospital, per time, per DRG was 80. The total sample size goal was 2,900 charts and 2,622 were reviewed. Table 4 illustrates the distribution of the sample by hospital.

In two hospitals, the universe of cases did not equal or exceed the required 80 cases per DRG, per time period. Anticipating that this might happen, the research team determined that all admissions within the pre/post time periods, including repeat admissions by the same patient, would be considered eligible for selection into the sample as long as the selection criteria were met. Where possible, over-sampling was done for the pre- and post- time periods to ensure an adequate pool of replacement cases for charts found to be ineligible.

Another problem encountered during the sample selection was that two hospitals did not have their pre-period Medicare admissions on an in-house computer. Thus, a hard-copy printout of Medicare admissions had to be used to identify eligible cases by hand. Two hospitals did not have their pre-period admissions listed by DRG. Thus, the research team had to use hard-copy listings of admissions to identify eligible cases using the ICDA codes in the sample DRGs. Additionally, one hospital was excluded from the sampling of surgical DRGs due to the length of time required to develop a valid list of cases eligible for selection. Finally, protocols had to be developed to coordinate the pulling and refiling of the medical records to ensure that all records were available for coding.

5. Data Collection

Data abstraction for the study sample took place between September, 1985 and April, 1986. Ms. Wilkinson coordinated the scheduling of data collection with each of the medical records directors. In consideration of the work load of the hospital records departments and the demands of this project (e.g., approximately 800 charts per hospital), all data collection was scheduled at least a week in advance. In addition, the hospitals required from three days to one week for pulling selected sample records for coding.

Data collection in each of the hospitals lasted from two to three months. Problems encountered in the data collection included the following. There was difficulty in scheduling data collectors due to hospital demands for abstracting only during certain hours. One hospital had its pre-period charts on microfiche, which made identification and abstraction more difficult and time consuming. Scheduling for data collection was awkward during high work load periods and while other studies were being conducted using the records departments. Data collection during vacation time (summer) and during the holidays (Thanksgiving and Christmas) proved to be problematic and it was often difficult to schedule part-time data collectors. However, these problems of scheduling, sample identification, and coordination with record departments were minor on the whole.

A total of 2,622 medical records were abstracted in this study: 593 from Hospital A; 648 from Hospital B; 509 from Hospital C; and 735 from Hospital D. Completion rates for data collection were extremely high with only five (5) charts from the entire sample being ineligible due to insufficient data in the medical record. A few charts were determined to be ineligible for other reasons, including: the patient expired on the identified admission; the chart could not be found or was being used on the floor for other purposes; the chart was out of the hospital being transferred to microfiche; the wrong identification number was typed on the list and the appropriate chart could not be identified; the length of stay was shorter or longer than the two to twenty-two days stay; or the DRG was wrong. Where there were replacements available, ineligible charts were replaced until 60 charts per DRG were coded or no other charts were available. The data was reasonably complete with no single variable having more than one percent (1%) missing data.

B. DATA ANALYSIS

The objective of the data analysis was to examine and test the differences in pre/post characteristics. The data analysis section is divided into six areas: descriptive information; length of stay; age; Dependency by DRG; Dependency class; hospital discharge disposition; and recommendation. For test of significance, the .05 level of probability was applied. For ease in presentation, the 1981-1983 period is labeled the pre and the 1984-1985 period is labeled post.

Descriptive Information

All record subjects were Medicare beneficiaries with 36% male and 64% female. The sample of 2,622 records included 1,264 (48%) in the pre-period and 1,358 (52%) in the post-period.

DRG	TOTAL	PRE	POST
Stroke (14)	632 (24.2%)	295 (46.7%)	337 (53.3%)
Pneumonia (89)	630 (24.1%)	289 (45.9%)	341 (54.1%)
Heart Failure (127)	733 (28.0%)	351 (47.9%)	382 (52.1%)
Hip Replacement (209)	371 (14.2%)	180 (48.5%)	191 (51.5%)
Major Joint Pinning (210)	248 (9.5%)	141 (56.9%)	107 (43.1%)
Total	100%		

A chi square test indicated that the pre- and post- samples were not significantly different based on distribution of DRG.

Length of Stay (LOS)

The measurement of LOS was constrained by the sampling methodology. We included in the study sample only those LOS between two and twenty-two days in order to limit the outlier effect.

The mean LOS for the five diagnostic groups in pre was 11.3 days and in post was 8.6 days. This represents a significant reduction of 2.7 days (Table 5). This reduction parallels the summary Medicare data from Multnomah County, Oregon, which reported a drop of 2.4 days LOS from 1982 to 1984 (OMPRO, 1986).

When LOS is examined by differences between medical and surgical, the medical DRGs (14, 89, 127) had far more variance (as measured by standard deviation) than surgical DRGs (209, 210) (Table 5).

In addition, when LOS is computed by DRG by pre/post period, there was a significant reduction in LOS in all DRGs (Table 5).

Age

The average age for the pre period was 80.3 years and for the post period 77.2 years. Rather than using age as a continuous variable, it was grouped into four age categories; 60-65, 66-75, 76-85 and 86+. The distribution of the two samples was:

Age Category	PRE (n=1228)	POST (n=1329)
60-65	2.4%	6.2%
66-75	24.5%	27.6%
76-85	39.5%	40.5%
85+	33.4%	25.7%

When tested by the chi square method, the difference is significant.

In disaggregating and comparing the data by DRG, an interesting pattern is evident (Table 6). There was a significant increase in the younger Age groups (60-85 years) for stroke, heart failure and hip replacement patients and a corresponding decrease in the 86+ Age group. No such pattern was seen for pneumonia and major joint pinning. Indeed, these two DRGs represent 41% of the admissions in the 86+ Age sample. If older patients are being admitted less often in certain DRGs, what factors are influential? Five changes between 1982 and 1984 might be contributory:

1. More stringent admissions criteria (e.g., higher acuity);
2. Coding differences (20% of the 1982 sample were coded on ICDA codes);
3. Upgrading of nursing homes - capacity to handle older stroke or heart failure patients who are having a subsequent episode;
4. Expansion of technological capacity (e.g., incentive to perform hip replacements at younger age);
5. Competition.

While more stringent admission criteria might apply across all DRGs, the issue of technological capacity does not. For example, our findings showed that patients who had hip replacements were significantly younger in the post-DRG period while at the same time, the Age distribution of patients receiving major joint pinning were proportionately equal in both pre- and post- time periods.

In comparing the three medical DRGs (stroke, pneumonia, heart failure), it is possible that the difference between the need for medical management, as opposed to nursing management, may account for older stroke and heart failure patients being cared for in nursing homes rather than being sent to hospitals. Pneumonia patients are, perhaps, being sent to hospitals for medical intervention.

Dependency by DRG

The DEPENDENCY SCALE that measured Dependency at the point of hospital discharge used four items: ACTIVITY, BATHING, PROCEDURES and SYMPTOMS. The scale ranges from 0 to 24. The average dependency for 1982 was 8.9 and for 1984 was 9.7. Applying a t-test, the difference is significant at the .001 level (Table 7). In some instances this difference (.8) may not have a great pragmatic value, but the instrument appears to be sensitive enough to detect small changes that could be important intrinsically or could grow over time. The scale provides a mechanism for analyzing readiness for discharge and could also provide a baseline from which to measure the effects of post-hospital sub-acute care.

Disaggregating the total is necessary to understand the differential impact of PPS on the five DRGs. Three out of five tests, based on individual DRGs, were significant. The three DRGs in which the data indicate a significant increase in Dependency are hip replacement (.001), heart failure (.01) and pneumonia (.05). See Table 7. The data did not indicate a significant increase in stroke and major joint pinning. The latter showed high Dependency for both the pre- and post- periods.

Finally, our data clearly indicate that the rise in dependency is not linear (Figure 2). Dependency rises more sharply for the higher age categories. The upper age groups had significantly more women. Therefore, the finding that women were more dependent than men is consistent with their representation in the upper age categories.

Dependency Class

In order to provide a more useful assessment framework, we decided to reduce the DEPENDENCY SCALE into four classes. These classes were:

Class I 0-5 : minimally dependent
Class II 6-11 : somewhat dependent
Class III 12-17 : moderately dependent
Class IV 18-24 : severely dependent

As can be seen in Table 8, in the post period, the proportion of Class I Dependency decreased. In all other classes the proportion increased. As tested by chi square, the difference between the pre and post periods was significant.

When Dependency class was examined in relation to length of stay, an interesting finding was evident. For the entire sample, mean LOS for Class I was 6.7 days; Class II 9.4 days; Class III 10.2 days and Class IV 9.6 days. One might expect that, as Dependency increased, LOS would also but this was not the case (Figure 3). One explanation may be that 49% of Class IVs came from nursing homes, suggesting that post-hospital placement might be more readily available.

Post-Hospital Discharge Disposition and Recommendation

We recorded data from the medical charts which listed the type of discharge disposition: home alone; home with another; group home; nursing home; another hospital; or unclear information. There was a tendency for more home discharge dispositions (measured as home alone and home with another) in the post- period than in the pre- period.

When examining "another hospital" discharge disposition, as compared to all others in the pre versus post periods, the difference is highly significant with $p < .001$ (chi square test). One explanation for this significant increase in post "other hospital" placements could be that the DRG we selected generally required rehabilitation support. But there may be an unbundling of services that were previously provided as one unit. Other evidence suggests that some beneficiaries are being stabilized and then transferred to other hospitals, particularly for rehabilitation services.

Finally, there was a slight increase in the number of home health service recommendations. However, it is not possible to separate the effect PPS had on home health service recommendations for post-hospital care.

V. SUMMARY AND FUTURE PLANS

This section summarizes the results of the "Dependency at Discharge" study. The "Dependency at Discharge" instrument was based on criteria relevant to the hospitalized population. The scale was composed of items identified from literature review and data available on patient hospital charts. The reliability results were very positive. Not only was the instrument convenient and reliable but it supported the use of secondary data for classifying patients. Based on the successful reliability results, as well as the tool's convenience for measurement of hospital records in lieu of direct patient observations, we believe the instrument warrants additional development; specifically, validity testing.

The study is limited by the lack of validity testing on the instrument, the pre/post design as well as the focused geographical sampling. Potentially, many factors could confound the results. We tested one; age, and found the pre/post samples to be significantly different. We could have tested other descriptive characteristics, economic climate or technological advances. Despite the limitations, however, the findings can be accepted with considerable confidence because of the careful methodology that was employed.

Of major interest is the age difference between the Pre-DRG sample and the post-DRG sample. The post sample was significantly younger (and significantly more dependent in certain DRGs). One explanation for this phenomenon is that the older, old are not being admitted unless they display acute medical symptoms. We hypothesize that they remain in other settings such as nursing homes and private homes, whereas in pre-DRG years they would have been admitted to a hospital. Many nursing homes have upgraded their staff and facilities and are capable of providing for heavy care patients. Therefore, the older old may be remaining in these other settings for those diagnoses that center on nursing intervention rather than medical treatment.

In addition to the change toward the younger beneficiary, Dependency scores increased in three of the five studied DRGs: pneumonia, heart failure and hip replacement. When considering this finding, it appears that the cost containment system is indeed having an impact on individual health status among patients in certain DRG classes. Whether this increased dependency influences the ability for the patient to recuperate in other settings could not be examined in this pilot study. Replication studies are needed before generalizing these findings to other DRGs.

Policy Implications

The first implication derived from this study is that discharge decision-making should incorporate a systematic approach for screening patients in preparation for hospital discharge. Further, we suggest that the screening method include a measure of patient Dependency, as defined in this study. Our evidence suggests that self-care limitations can be reliably estimated by rating mobility, bathing, care procedures and symptoms. The cluster of these parameters provides a more discriminating assessment than do any of the individual elements. Eventually this approach could enable a more appropriate match between patient needs and continuing care resources.

A second policy implication concerns progressive differences in the health care system configuration. The focus of hospitals has evolved from a broad scope of health disability care to a narrow scope of strictly defined acute medical care. Hospitals are realizing cost savings due to reduced lengths of stay but patients are now leaving the hospital in a more dependent state in certain DRGs. The inference here is that post-hospital care facilities and agencies need to be adequately equipped, financed and prepared to accommodate this shift. Quality care standards should not be dependent on setting. We recognize the need for care review and strongly support the development of post-hospital care policy which will enable adequate services for Medicare beneficiaries.

In conclusion, we believe that future work should include investigations pertaining to Dependency in: other representative DRGs; other hospital settings; other regions of the country; and other health care delivery settings, such as nursing homes, group homes and private homes. NOHS is committed to continuing this important research so that we can better understand the impact of policy on the health of a major portion of America's population.

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VII. APPENDIX

Dependency at Discharge Tool

NORTHWEST OREGON HEALTH SYSTEMS
DEPENDENCY AT DISCHARGE*

By: Patterson, Coe, and Wilkinson

	← DEGREE OF DEPENDENCY			
	+6	+4	+2	0
ACTIVITY AND MOBILITY	in bed always; needs turning assist; if able to transfer, needs 2-person assist to chair or commode ______	in bed mostly; turns self in bed; needs 1-person assist to transfer or walk a few feet or help with wheelchair or walker ______	walks around room, uses bathroom; may require standby assist or walker if SOB, dizzy, weak; ______	walks independently, ad lib; uses hallway; no symptoms with activity; no assist devices ______
BATHING AND HYGIENE	bedbath with total assistance and some or total assistance with oral hygiene ______	needs moderate assist to complete bath but is able to manage own oral hygiene; washes at bedside ______	needs minimal, but some assist for safety to bathe or shower; washes self if done in bed; completes own oral hygiene ______	independent with bath or shower; washes in BR only ______
MEDICATIONS	10 + Rxs or has IV order ______	7 - 9 Rxs or needs IM ______	4 - 6 Rxs or needs SQ ______	0 - 3 Rxs ______
PROCEDURES	tube feedings; decubitus care; intermittent cath; wet/dry dressings; hyperalimentation ______	indwelling catheter; ostomy care; continuous respirator; complex dry dressings ______	oxygen; nebulizer; simple sterile dry dressing; strengthening exercises; sling; ace wrap; TED hose; IV site care ______	none noted ______
SIGNS AND SYMPTOMS	frequent urinary or fecal incontinence; disorientation or persistent confusion; multiple, frequent, or severe sx ______	dizziness, pain, nausea, generalized weakness, fatigue, unsteadiness; signs of moderate anxiety or depression; stress incontinence; inability to concentrate; mod severity or several mild sx ______	minimal weakness, dyspnea on exertion, occ/scattered rales; sl ankle swelling; mild confusion, anxiety, or memory loss ______	no symptoms ______
YEAR OF BIRTH	before 1900 ______	Jan 1900 to Dec 1909 ______	Jan 1910 to Dec 1919 ______	after Dec 1919 ______

TOTAL POINTS

______

CLASSIFICATION

I.______
II.______
III.______
IV.______

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TABLE 1

RELIABILITY RECORD SAMPLING DESCRIPTION

			NUMBER OF CASES							
TIME	HOSPITAL	NO. OF RATERS	PRE DRG	POST DRG	DRG					TOTAL
					14	89	127	209	210	
1	A	3	5	6	5	2	4	0	0	11
1	B	3	6	4	4	3	3	0	0	10
1	C	3	0	8	3	4	1	0	0	8
1	D	3	6	4	3	3	4	0	0	10
2	C	3	9	9	6	6	6	0	0	18
2	D	3	0	11	0	11	0	0	0	11
3	C	3	5	8	5	5	3	0	0	13
2	B	7	7	7	2	4	8	0	0	14
3	A	6	11	14	5	4	6	6	4	25
3	B	6	13	12	6	4	4	5	6	25
3	D	6	9	8	0	0	0	8	9	17
TOTALS			71	91	39	46	39	19	19	162
PERCENT OF TOTAL			44	56	24	28	24	12	12	

TABLE 2

INTER-RATER PEARSON CORRELATION MEANS FOR ITEMS AND DEPENDENCY SCALES BASED ON SIX AND FOUR ITEMS

SAMPLE	ACTIVITY	BATHING	MEDS	PROCEDURES	SYMPTOMS	AGE	DEPENDENCY (6)	DEPENDENCY (4)
1	.79	.83	.82	.81	.86	1.00	.93	.91
2	.82	.91	.50	.80	.63	1.00	.96	.95
3	.86	.94	.68	.76	.73	.59	.95	.95
4	.30	.69	.72	.79	.48	1.00	.76	.82
5	.90	.85	.70	.84	.77	1.00	.94	.95
6	.71	.86	.72	.93	.73	1.00	.88	.88
7	.91	.81	.86	.82	.96	1.00	.93	.96
8	.63	.73	.80	.78	.62	1.00	.84	.82
9	.76	.77	.67	.62	.63	.98	.89	.87
10	.83	.74	.87	.72	.79	.95	.92	.91
11	.75	.75	.65	.61	.70	1.00	.90	.87
MEDIAN	.80	.82	.72	.80	.73	1.00	.92	.91
MEAN*	.79	.82	.75	.79	.79	.99	.92	.91

*Mean Correlation Based on r to z Transformation

TABLE 3

INTER-ITEM CORRELATIONS AND ALPHA COEFFICIENTS FOR THREE SCALE VERSIONS

Inter-Item Correlations

	ACT	BATH	MEDS	PROC	SYMP	AGE
ACTIVITY	1.00					
BATH	.78	1.00				
MEDS	.11	.12	1.00			
PROCEDURES	.55	.53	.08	1.00		
SYMPTOMS	.65	.64	.15	.50	1.00	
AGE	.11	.11	.02	.03	.09	1.00

Alpha Coefficients

Scale 1: ACT/BATH/MEDS/PROC/SYMP/AGE Alpha Coefficient = .78
Scale 2: ACT/BATH/PROC/SYMP/AGE Alpha Coefficient = .82
Scale 3: ACT/BATH/PROC/SYMP Alpha Coefficient = .86

TABLE 4

DISTRIBUTION OF SAMPLE: DESIRED AND ACTUAL

DESIRED

	PRE 10/81 - 9/83	POST 4/84 - 7/85	TOTAL
Medical DRG (14, 89, 127)			
Hospital A	250	250	500
Hospital B	250	250	500
Hospital C	250	250	500
Hospital D	250	250	500
Surgical DRG (209, 210)			
Hospital B	150	150	300
Hospital C	150	150	300
Hospital D	150	150	300
			2,900

ACTUAL

	PRE 10/81 - 9/83	POST 4/84 - 7/85	TOTAL
Medical DRG (14, 89, 127)			
Hospital A	194	236	430
Hospital B	238	316	554
Hospital C	259	250	509
Hospital D	245	260	505
Surgical DRG (209, 210)			
Hospital B	45	151	196
Hospital C	112	87	199
Hospital D	164	65	229
			2,622

TABLE 5

LENGTH OF STAY

SUMMARY

(N=2,528) Mean Days	Deviation	Standard t-value	
PRE (1,208)	11.3	4.9	
POST (1,320)	8.6	3.8	15.01***

BY PRE/POST

		Mean Days	Standard Deviation	t-values
DRG 14	(Stroke)			
	PRE (277)	11.4	5.3	
	POST (327)	7.7	3.3	10.10***
DRG 89	(Pneumonia)			
	PRE (276)	9.6	4.3	
	POST (336)	7.8	3.5	5.16***
DRG 127	(Heart Failure)			
	PRE (336)	9.2	4.7	
	POST (372)	7.2	3.1	6.67***
DRG 209	(Hip Replacement)			
	PRE (177)	15.5	3.6	
	POST (189)	12.3	3.6	8.27***
DRG 210	(Major Joint Pinning)			
	PRE (134)	13.8	4.3	
	POST (104)	11.5	3.8	4.45***

***p<.001

TABLE 6

AGE DISTRIBUTION BY PRE/POST AND DRG

Age			
Total Sample*	PRE (n=1228)	POST (n=1329)	TOTAL (n=2557)
60-65	2.4%	6.2%	4.1%
66-75	24.5%	27.6%	26.1%
76-85	39.5%	40.5%	40.4%
85+	33.4%	25.7%	29.4%
Stroke	PRE (n=285)	POST (n=328)	TOTAL (n=613)
60-65	1.8%	3.0%	2.4%
66-75	20.7%	30.2%	25.8%
76-85	44.2%	45.4%	44.9%
86+	33.3%	21.3%	26.9%
Pneumonia	PRE (n=278)	POST (n=331)	TOTAL (n=609)
60-65	2.2%	8.2%	5.4%
66-75	26.3%	23.0%	24.5%
76-85	35.6%	33.2%	34.3%
86+	36.0%	35.6%	35.8%
Heart Failure	PRE (n=345)	POST (n=372)	TOTAL (n=717)
60-65	1.2%	3.5%	2.4%
66-75	20.3%	29.3%	25.0%
76-85	41.4%	41.7%	41.6%
86+	37.1%	25.5%	31.1%
Hip Replacement	PRE (n=180)	POST (n=191)	TOTAL (n=371)
60-65	6.7%	9.9%	8.4%
66-75	36.7%	34.0%	35.3%
76-85	35.6%	46.1%	41.0%
86+	21.1%	9.9%	15.4%
Major Joint Pinning	PRE (n=140)	POST (n=107)	TOTAL (n=247)
60-65	2.1%	6.5%	4.0%
66-75	23.6%	16.8%	20.6%
76-85	39.3%	39.3%	39.3%
86+	35.0%	37.4%	36.0%

*Chi square method, the difference is significant.

TABLE 7

DEPENDENCY SCORES BY PRE/POST AND DRG

Overall Dependency By Period

PRE	POST	t-value
8.9	9.7	3.79***

Dependency By Period By DRG

	PRE	POST	t-value
Stroke	11.2	12.3	1.89
Pneumonia	7.9	8.9	1.99*
Heart Failure	6.5	7.5	2.53**
Hip Replacement	7.9	9.4	4.01***
Major Joint Pinning	12.3	12.4	.22

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 8

PERCENT DISTRIBUTION OF SAMPLE BY DEPENDENCY CLASS

	PRE (n=1256)	POST (n=1358)	TOTAL (n=2614)
Class I	28.7	22.5	25.5
Class II	42.8	44.2	43.5
Class III	15.1	17.5	16.4
Class IV	13.3	15.8	14.6
Total	100. %	100. %	100. %

Chi square test = ***$p < .0014$

TABLE 9

PERCENT OF DISCHARGE PLACEMENTS BY DEPENDENCY CLASS AND PRE/POST PERIOD

	DEPENDENCY CLASS:										
	I		II		III		IV		TOTAL	PRE	POST
Placement	Pre	Post	Pre	Post	Pre	Post	Pre	Post			
Home Alone	7.7	7.5	5.7	6.1	.3	.4	0	.1	13.9	13.7	14.1
Home With Other	18.0	13.0	27.4	27.3	5.6	5.5	1.4	1.8	49.9	52.3	47.7
Group Home	1.0	1.0	1.6	3.0	.5	1.0	.3	.4	4.5	3.4	5.5
Nursing Home	.6	.7	7.4	5.3	8.1	8.0	11.2	12.0	26.7	27.4	26.0
Hospital	.2	.1	.5	2.1	.6	2.4	.4	1.5	4.0	1.7	6.1
Information Unclear	1.0	.2	.4	.3	.1	.1	0	0	1.1	1.5	.7
Column Total	28.6	22.5	42.9	44.2	15.2	17.4	13.3	15.9	100 %	100 %	100 %

Chi Square Test For

Home versus all other by Pre/Post Chi Square value = .003*

Hospital versus all other by Pre/Post Chi Square value = .000***

* $p < .05$
*** $p < .001$

LIST OF FIGURES

1. Distribution of DEPENDENCY Scores by PRE/POST

2. Mean DEPENDENCY Scores by Age Category for PRE/POST

3. Length of stay by DEPENDENCY Class

Figure 1

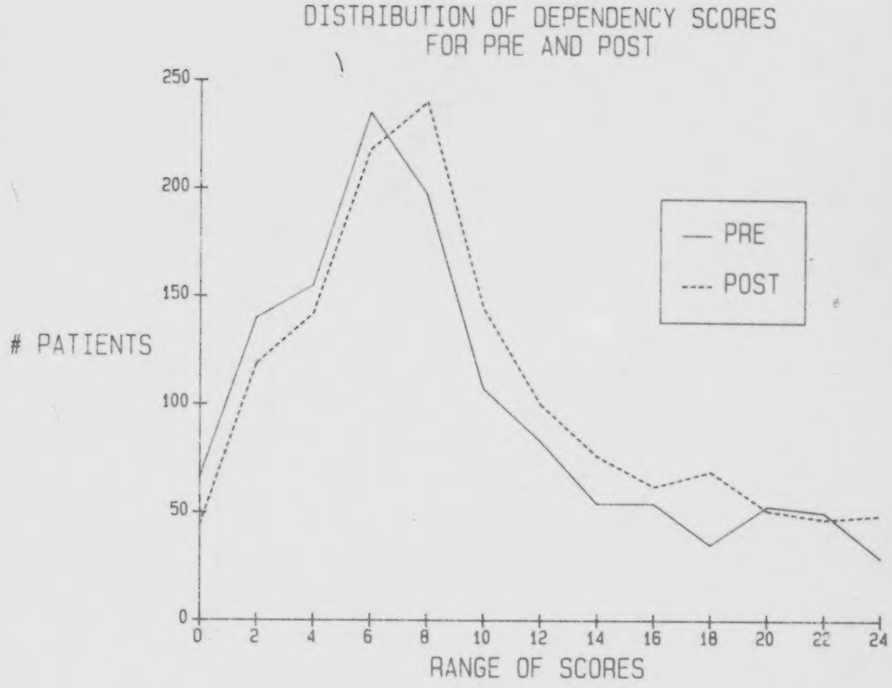
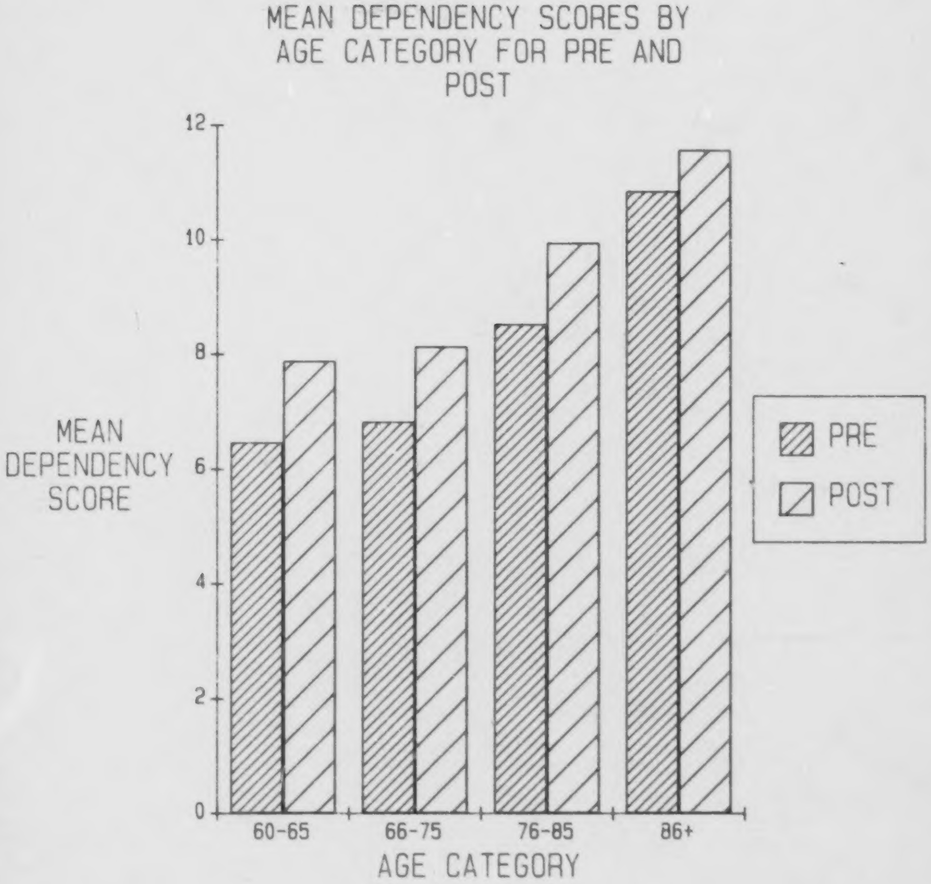

DISTRIBUTION OF DEPENDENCY SCORES
FOR PRE AND POST
# PATIENTS
250
200
150
100
50
0
0
2
4
6
8
10
12
14
16
18
20
22
24
RANGE OF SCORES
PRE
POST

Figure 2


MEAN DEPENDENCY SCORES BY AGE CATEGORY FOR PRE AND POST
MEAN DEPENDENCY SCORE
0
2
4
6
8
10
12
60-65
66-75
76-85
86+
AGE CATEGORY
PRE
POST

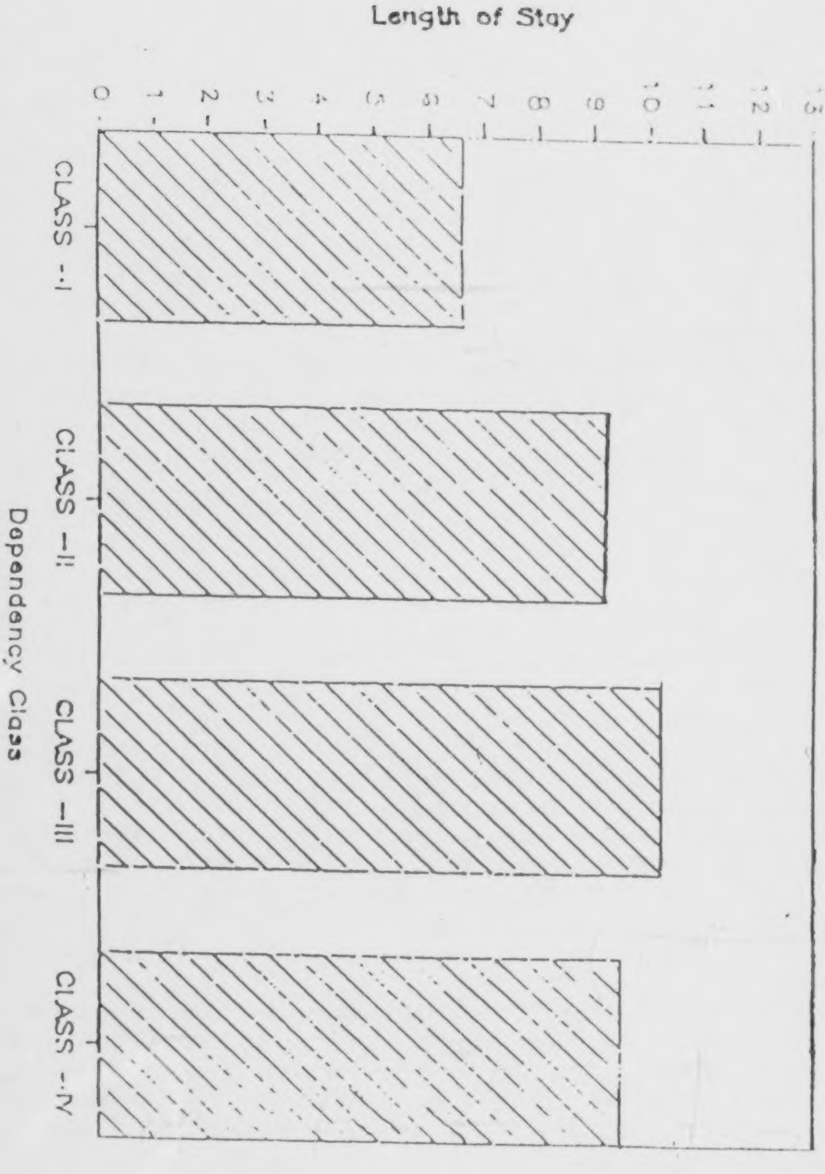


FIGURE 3

Length Of Stay By Dependency Class

STATEMENT OF MARK RUSSELL CHASSIN, M.D., M.P.H., M.P.P., SENIOR PROJECT LEADER, THE RAND CORP., SANTA MONICA, CA

Dr. CHASSIN. Mr. Chairman, members of the committee, my name is Mark Chassin. I am a practicing physician and a health services researcher at the Rand Corp.; also, I was deputy director of the Office of PSRO's at HCFA from 1979 to 1981. Thank you very much for inviting me to discuss this important issue with you this morning.

Let me start by saying that quality care research has come a long way in the last decade, thanks in no small part to projects funded by Federal agencies such as the National Center for Health Services Research and HCFA. We can now measure quality of care, health status, and other health outcomes, as the study just described illustrates.

Unfortunately, these methods have not been applied in a systematic or rigorous way to the Medicare Program, and thus our knowledge about the quality of care provided to Medicare beneficiaries is quite limited. We know very little indeed about how quality has been affected by prospective payment.

Let me tell you briefly about three major studies that we are now conducting that illustrate some of the most important unanswered questions about quality of care. Following on the work of others, we have documented very large geographic differences in the use of health services in the Medicare population. If high rates of use are synonymous with large amounts of overuse, we might have an easy way to monitor this aspect of quality of care, simply by counting procedures and calculating rates of use. However, we know very little about what explains these large geographic differences. Overuse in high-use areas may play a role, but underuse in low-use areas may also be an important factor.

Further, both high- and low-use areas might be correct if the occurrence of particular diseases varies significantly by geographic area. We are now in the final phase of a 4-year study that will measure the extent to which inappropriate overuse in high-use areas explains geographic differences in the use of three specific procedures.

Evidence is accumulating that outcomes of hospital care, for example in-patient death, vary widely among hospitals. If poor outcomes are consistently related to poor quality of care, again we might have a relatively inexpensive and timely way to monitor hospital quality of care. The recent publication by HCFA of lists of hospitals with higher and lower than expected death rates underscores both the extent of the problem and our lack of understanding of its causes.

Why should one hospital have a death rate for patients with heart attacks of 40 percent and another experience only a 10-percent mortality? Are the patients at the first hospital that much sicker than those at the second? We simply do not understand the circumstances under which quality of care plays a major or a minor role in creating differences like these.

We are now about midway through a 3-year study that will measure the extent to which hospitals with unusually high death rates provide poorer quality of care or treat sicker patients than similar hospitals with lower death rates.

When it comes to prospective payment, we have no definitive data on how it has affected quality of care overall. Why don't we know more? I think there are at least four important reasons.

First, there has been little systematic research on the quality of care provided to Medicare beneficiaries. Therefore, we don't have much data on quality of care before prospective payment was initiated. It is difficult to measure change when you don't know very well where you started from.

Second, measuring quality of care is a difficult task. To be clinically accurate, measuring quality requires a lot of data. For example, each of the forms that we use in the geographic differences study to collect data for medical records is over 100 pages long and takes an hour to complete; and that is just to assess one case. Quality of care may also change over time. Last year's definitions of good quality often don't apply today; neither do last year's measures of quality.

Third, in assessing the effect of prospective payment, we must be comprehensive and unbiased. While it is certainly possible that the quality of care may be adversely affected by per-case payments, it is also possible that quality may have improved. If physicians and hospitals are able to reduce length of stay and services appropriately, then patients will benefit by being spared exposure to the adverse effects of these unneeded hospital treatments.

Finally, prospective payment was not implemented in a fashion that facilitated its evaluation. It was not begun as an experiment with carefully constructed control groups, nor was enough planning devoted to the development of the evaluation methods required to measure its impact. We are just beginning a comprehensive study of the effect of prospective payment on quality of care. We will examine some 20,000 patient records in six States from time periods before and after the implementation of prospective payment.

In conclusion, let me emphasize that, although there are important unanswered questions concerning quality of care in the Medicare Program, we are making progress toward answering them. The research is expensive, and it is time consuming, but it will produce answers. Thank you.

Senator DURENBERGER. Thank you, Dr. Chassin. Dr. Anderson.

[The prepared written statement of Dr. Chassin follows:]

Statement Submitted to the Senate Finance Committee

Quality of Care and Medicare's Prospective Payment System

Mark R. Chassin, M.D., M.P.P., M.P.H.
Senior Project Director
The Rand Corporation

June 3, 1986

Prospective per case hospital reimbursement represents the most radical change in health care financing in this country since the enactment of the Medicare and Medicaid legislation in 1965. Establishing the Prospective Payment System (PPS) fundamentally changed the financial incentives faced by hospitals providing medical care to Medicare beneficiaries. In this statement I will briefly review the major aspects of these changes and discuss their implications for quality of care. I will also discuss the major unanswered questions concerning the impact of PPS and other recent financing changes on the quality of care received by Medicare beneficiaries and summarize some research now in progress to answer these questions.

Summary of New Incentives

Because hospitals receive payments on a per case basis under PPS, they are encouraged to provide as few services at as little cost as possible to each patient. This incentive affects virtually all hospital services. For example, the use of intensive care units (ICUs) is markedly discouraged since these areas of the hospital provide some of its costliest services. Hospitals are under pressure to reduce their ICU capacity. Similarly, hospitals may also consider reductions in staffing of nurses in ICUs and regular wards and of other personnel in other departments.

Some hospitals may decide that certain services are no longer worth the cost to provide and that many new services may not be worth their cost to acquire. This trend is beginning in many institutions in the limitation of pharmacy services by reducing the available scope of drugs, often focusing first on expensive antibiotics. Similar reductions in high-cost laboratory, radiologic, or therapeutic services may also be considered. The spread of some new technologies such as the latest generation computed tomographic scanners and magnetic resonance imaging devices may be sharply curtailed as a result of PPS.

Hospitals now have a strong incentive to discharge patients earlier than they might have prior to PPS since their payments are largely independent of length of stay. This is perhaps the most often discussed new incentive.

PPS also strongly encourages hospitals to increase the number of admissions to their facilities. This may be accomplished either by increasing the number of patients treated or by dividing what might once have been single admissions into multiple hospital stays. For example, certain staged surgical procedures formerly performed during a single admission might now be candidates for two or more stays. Multiple medical problems may not all be evaluated during the same admission.

Further, and perhaps more insidious, is the incentive hospitals now have to avoid admitting the sickest patients within any particular diagnosis related group (DRG). If a hospital can succeed in admitting only the least sick patients within a DRG, then it will be likely to retain a larger share of the DRG payment in excess of its costs because the payment is based on an average of all patients within the DRG.

Implications for Quality of Care

The implications of these incentives for quality of care are clear. If hospitals provide fewer inpatient services than medically appropriate to patients, quality of care will suffer. For example, if a hospital cuts back so far on its supply of cardiac monitoring facilities that not all patients with acute ischemic heart disease can be monitored, it is likely that some unmonitored patients will suffer potentially treatable arrhythmias, that these will go unnoticed, and that adverse outcomes will ensue.

Similarly, if patients are discharged from hospitals before medically appropriate and without adequate post-hospital arrangements for care, their acute illnesses may worsen, necessitating additional potentially avoidable inpatient care and potentially leading to poor outcomes. Such premature discharges will constitute a considerable burden for the families, home health care agencies, and nursing homes that find themselves faced with the care of patients who are too ill to be adequately cared for with the resources at hand.

Hospitals may increase admissions inappropriately by admitting patients who could more properly be cared for in outpatient settings. This inappropriate exposure of patients to the adverse effects of hospital care would have a negative effect on the quality of their care.

Finally, if hospitals attempt to avoid admissions of some of the sickest patients, inappropriate patient transfers could result. If medically unstable patients are moved from one hospital to another, the quality of their care will clearly suffer.

On the other hand, PPS may actually result in improved quality of care. If hospitals reduce the amount of service provided to patients appropriately, then only unneeded or marginal services may be eliminated. Patients will benefit to the extent they are spared the adverse effects these services carry with them.

Similarly, if patients can be discharged earlier than in the past in a medically appropriate fashion, then their exposure to nosocomial infection and iatrogenic disease will be reduced. Under these circumstances, too, quality of care will increase.

Hospitals may also increase admissions in an appropriate manner. For example, if a surgical condition is diagnosed during a hospital stay for a medical condition, it may be quite proper to allow the patient to recuperate fully at home before readmission for surgery.

Lastly, it is conceivable that some hospitals should not be caring for the sickest elderly; they may not have the most appropriate facilities to provide the best care to this subgroup of patients. If such patients are transferred in medically appropriate ways, even their quality of care may improve.

What We Know About Quality Under PPS

If the potential effects of PPS on quality of care are easy to catalog, its actual impact is far from clear. A large number of individual reports have appeared in the various media and have been aired before other congressional committees, suggesting that individual patients have suffered as a result of PPS. However, we have no hard data with which to judge the overall impact of PPS on quality of care. We do not know whether these anecdotal reports represent the tip of an iceberg or an ice cube floating on the surface of the ocean. It is unfortunate but true that poor quality of care existed before PPS; we do not know whether its frequency has increased, stayed the same, or decreased.

Preliminary data suggest that length of stay, admission rates, and even ICU use may have fallen since the advent of PPS. However, we know nothing about the extent to which these changes, if they have taken place, have occurred in medically appropriate or inappropriate ways. Without precise and comprehensive clinical data, we cannot infer any conclusions about quality of care. As already discussed, any or all of these changes could be associated with either improved or diminished quality of care.

The Rand Corporation has recently begun a major study the Health Care Financing Administration (HCFA) designed to assess the effects of PPS on quality of care. We will examine the medical records of some 20,000 patients hospitalized with one of six common medical and surgical conditions: congestive heart failure, acute myocardial infarction, pneumonia, hip fracture, cerebrovascular accident, and depression. We will study patients in six states--representing each major geographic region of the country--from time periods before and after the implementation of PPS. We also are in the planning phase of a study that would determine the extent to which Medicare readmissions are preventable and therefore attributable to poor quality of care.

Remaining Unanswered Questions About Medicare and Quality of Care

Geographic Differences in Use of Health Services

In addition to the question of the direct impact of PPS on quality of care, there are several important, unanswered questions with profound implications for the quality of care experienced by Medicare beneficiaries. Foremost among them is: Why do such large variations exist among geographic areas in the rates of use of health services? Following on the work of others, we have documented very large differences in the rates of use of a wide variety of medical and surgical services among the Medicare population. For example, the rates of use of coronary artery bypass surgery differ by as much as three-fold.

We studied large geographic areas--about the size of an average state. The average Medicare population in our sites was 340,000. The differences we observed, therefore, cannot have been caused by a few physicians or groups of physicians. For example, if the area with the highest rate of use of coronary artery bypass surgery had had the rate observed in the area with the lowest rate of use of that procedure, about 1000 fewer coronary bypasses would have been performed in that one area in the year we studied.

If areas with high rates of use of health services are providing a large amount of unnecessary services, then we might have a relatively inexpensive way of monitoring quality of care. All we would have to do is count procedures and calculate rates of use. We could then target scarce utilization review resources on areas of high use for specific procedures.

However, we know very little about the causes of the large geographic differences we observe. Inappropriate overuse in high-use areas may be an important factor in some instances. But underuse in low-use areas may also play a significant role. Further, both high- and low-use areas might be correct if the incidence of particular diseases varies enough by geographic area. It is likely that a different combination of these factors will explain variations in the use of different services.

We are now in the final phase of a study funded both by HCFA and private foundations that will measure the extent to which inappropriate overuse in high-use areas explains geographic differences in the use of three specific procedures: coronary angiography, upper gastrointestinal endoscopy, and carotid endarterectomy. We are studying a randomly selected sample of medical records from areas with high, average, and low use of these procedures. We have received excellent cooperation from the medical community; over 90% of physicians and 98% of hospitals are participating in the study. Results will be available in early 1987.

Variations in Outcomes of Hospital Care

Evidence is accumulating that outcomes of inpatient care--for example, hospital deaths, readmissions, or deaths shortly following hospital discharge--vary widely among hospitals. If poor outcomes are caused by poor quality of care, again we might have a relatively inexpensive and timely way to monitor quality of care. Data on death and readmission are relatively easily available from the Medicare data system, and reports summarizing these data by hospital could be produced on a quarterly or semiannual basis.

Unfortunately, we know very little about the relationship between these differences in outcomes among hospitals and quality of care. A few studies have been done that demonstrate persistence of such differences even after careful adjustment for differences in severity of illness. No study has attempted to study this relationship directly by measuring both quality and severity in a clinically detailed manner. Thus we do not now know whether these differences are produced primarily by differences in patient severity or by differences in quality of care.

We are now about midway through a three-year study for HCFA that will measure the extent to which hospitals with unusually high death rates provide poorer quality of care or treat sicker patients than comparable institutions with lower death rates. Using a data base of more than 10 million Medicare hospital stay records, we are also studying the degree to which hospital outcomes vary and the patterns of these variations.

Prepaid Health Care

While PPS has received the most public attention as a potential cause of declining quality of care among the elderly, other changes in health care financing may pose similar threats because they too provide incentives for providers to ration care. Recent changes in regulations governing health maintenance organizations (HMOs) and other forms of prepaid health care have made the Medicare population a more attractive market for their services than has been true in the past. More and more Medicare beneficiaries are signing contracts with such organizations which then become their sole source of medical care.

What do we know about the impact of prepaid health care on quality of care? A recent study from the Rand Health Insurance Experiment has documented that prepaid health care as provided by a traditional HMO is as good as fee for services care for the average patient; it however may be harmful to the health of small subgroups of the population. In particular, the Rand study showed that low-income persons with significant health problems fared worse in the HMO than in the usual fee for service medical system. It is important to note that the elderly were not included in this experiment, but its results provide reason for concern.

Traditional HMOs have very little experience in providing health care to the elderly. Whether HMOs can achieve economies similar to those realized in caring for the nonelderly is an open question. So is the question of whether any economies can be realized without impairing quality of care.

Rising Copayments

When Medicare took effect in 1966, patients were responsible for the first $40 of hospital care and the first $50 of physician services. They paid a premium of $3 per month for enrollment in part B of Medicare and were responsible for paying 20% of what Medicare determined the "reasonable charge" to be for physician services. The amounts that beneficiaries are required to pay today, 20 years later, are many times those of these first charges, even when inflation is accounted for.

What is the impact of rising copayments on quality of care? Once again the Rand Health Insurance Experiment provides some cause for concern. Increased cost sharing appeared to have little or no adverse effect on the average patient. However, patients with poor vision and low-income patients with high blood pressure had significantly poorer health outcomes when confronted with copayments than when their care was free. Again, it is important to note that this study excluded the elderly, but its results suggest that certain subgroups of patients may be harmed by increasing copayments.

Conclusions

In conclusion, the most striking characteristic of our knowledge concerning the quality of care provided to Medicare beneficiaries is how little there is of it. There was little systematic research on quality of care in the Medicare program before PPS, and we know even less about how it has changed since the advent of PPS. The same is true for how other financing changes--such as increased prepaid health care and rising copayments--have affected the quality of care received by the elderly. Nor can we explain two other phenomena with important implications for quality of care: geographic differences in the use of health care services and variations among hospitals in outcomes of care such as inpatient mortality.

Research is now in progress to answer some of these important questions. We have the technical capability to provide the necessary information. This research is expensive, and it does take time. But it will produce answers.

STATEMENT OF GERARD F. ANDERSON, PH.D., ASSOCIATE DIRECTOR, THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT; AND ASSOCIATE PROFESSOR, HEALTH FINANCE AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Dr. Anderson. Thank you, Mr. Chairman and members of the committee. My name is Dr. Gerard Anderson. I am an associate professor of health policy and management and the associate director for the Center for Hospital Finance and Management at Johns Hopkins University.

It has been said by a number of earlier speakers that it is extremely difficult to measure precisely when Medicare has gone too far in controlling health care costs and what are the effects on beneficiaries in paying hospitals inappropriately for treating certain types of cases. Our ability to develop precise measures of quality of care or access to care is not very well defined. Therefore, the temptation of policymakers, concerned primarily with the Federal deficit, is to control hospital costs, very heavily, and not to make fundamental reforms in the system.

The administration's current regulations to allow a very small increase in prospective payment rates in fiscal year 1987 is based partially upon our inability to measure the effect of past reductions on quality of and access to care.

In order for an indicator to be useful to most policymakers, I would suggest that it must have three characterics. First of all, the indicator should identify the problem before it becomes severe. It should be a leading indicator, similar to leading economic indicators. Otherwise, the damage has already been done before we know there is a problem. Second of all, there should be a direct link between the hospital payment and the adverse outcome. Otherwise, it will be easy to argue that a lot of other factors have caused the problem.

And third of all, the methodology should be comprehensible to the informed public. Otherwise, there is a danger that it will be ignored. Unfortunately, these three fairly simple constraints rule out most quality and access indicators that we have available.

There are a number, however, of quality indicators that have been frequently suggested, and there is some limited data on two quality indicators.

First of all, there has been a relatively marginal increase in hospital readmission rates since the beginning of prospective payment system, suggesting the hospitals and physicians are not discharging and then readmitting patients any differently than before. This is contrary to what some analysts, including myself, had predicted, and one indication that earlier discharges are not leading to increased readmissions. Readmissions, however, still are a problem because between 22 and 25 percent of all Medicare beneficiaries are readmitted within 60 days, and this has the cost to the Medicare program of about $8 billion.

The decline in the length of stay will result in patients being discharged both sicker and quicker almost by definition. You reduce 2 days' length of stay, and you get a sicker and quicker discharge. However, the data suggest the decline of length of stay began prior to the Medicare prospective payment system. The national average now is down to the west coast average that existed prior to the passage of the Medicare prospective payment system, and I know of no one who believes that patients discharged on the west coast in 1982 were being discharged too early.

The problem, as we have heard earlier, is that the postdischarge services are not available in many parts of the country to treat these patients being discharged earlier. You see tremendous variations by States in nursing homes and home health agency availability, and it hasn't changed substantially in the last 2 to 3 years.

So, most of the blame, I would think, can be given to States and to the Federal Government who have reduced payments and have reduced eligibility for these services at the same time when they are needed. Among the access indicators, there is also a little bit of data.

There has been no substantial increases in hospital closures, as many had predicted. Another thing is that we were originally concerned about is the access to high-cost technologies would be denied under PPS. We have recently committed a study of TPN, total parenteral nutrition, a high-cost-treatment modality that is not adequately reimbursed under PPS. Patients requiring the same DRG who require TPN are approximately $30,000 more expensive to treat than patients not requiring TPN; and although the economic incentives are there to reduce access to this treatment, none of the physicians we contacted, not the Association for Parenteral and Enteral Nutrition felt any pressure to curtail the use of TPN.

We also did some other treatment modalities and found similar results.

In summary, there are no indications that quality of care or access to care has declined as a result of PPS, but quality and access are extremely difficult to measure. The temptation therefore, is not to increase the payment, not to reform the system, because the impact cannot be measured.

The problem may be our measures and not that the system is working properly.

Senator **Durenberger**. Thank you.

[The prepared written statement of Dr. Anderson follows:]

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Mr. Chairman:

I am Dr. Gerard Anderson. I am an associate professor of health policy and management and the associate director of the Johns Hopkins Center for Hospital Finance and Management.

I believe that this hearing is especially important, given the history of health policy in the United States. The incremental nature of our policymaking process requires a long time to identify and then react to problems. Frequently once a consensus on the need for change has been reached, the government tends to overreact, which leads to adverse consequences. My concern is that the current emphasis on cost containment will reduce our concerns over quality of care. This is especially a concern given the difficulty of measuring quality of care and the ease of measuring hospital expenditures.

Federal precedent for overreaction can be illustrated with two examples: hospital beds and the physician supply. At the end of World War II, there was a consensus that we needed more hospital beds. Congress passed the Hill-Burton legislation to provide grants and loans for hospitals to expand. By early 1960, Congress decided that there were too many hospital beds, and so Congress responded by passing PL 92-641 and section 1122 to regulate their supply. Similarly, in the 1950s and 1960s there was the consensus that more physicians were necessary, the federal government responded by promoting the expansion of medical schools and graduate medical education. By 1980, the GMENAC report claimed that the nation would have a substantial surplus of physicians as early as 1990. By that time, Congress had already begun eliminating support for medical schools.

It is possible that a similar situation may occur with the cost containment efforts. When the Medicare and Medicaid programs were adopted in 1965, the major concern was the participation of hospitals and physicians. Generous reimbursement systems were developed in order to ensure that hospitals and physicians would provide care to Medicare and Medicaid beneficiaries. The result was a rapid growth in medical care spending. Through the late 1960s and most of the 1970s, there were numerous legislative and administrative proposals to reform the Medicare reimbursement system to control inflation in the health care sector.

After years of debate, a consensus was reached in 1981 that the public was willing to act to control rising hospital costs. Congress passed legislation giving states more flexibility to set payment rates in the Medicaid program. The passage of TEFRA and PPS legislation in 1982 and 1983 initiated controls on the rate of increase in Medicare's hospital payment rates and reformed the hospital payment system. The federal government was given broad powers to set hospital payment rates. Congress has used this power to reduce the rate of increase in subsequent years below the rates stipulated in the original TEFRA and PPS legislation. Congress made these decisions without much information on the impact that these changes would have on quality of care. It is important to examine the effect of payment reform on Medicare beneficiaries, hospitals, and the public.

Congress was able to change the hospital payment system in 1983 for several reasons. First, there were strong indicators that we were spending more on health care and especially hospital care each year. The rapid increases in the hospital inflation rate and the increasing proportion of the GNP represented by health care spending were clear and unmistakable indicators to the public and most policy analysts that health care costs were rising and that controls were necessary.

A second factor was that the health care system was not allocating existing resources appropriately. One of the rationales given for PPS was that costs of treating similar cases varied substantially across hospitals. According to the PPS Report to Congress, which originally proposed the legislation, "an examination of Medicare records shows that payments for treating a heart attack average $1500 at one hospital and $9000 at another with no apparent difference in quality. Likewise Medicare payments for hip replacements can vary from $2100 to $8200 and payments for cataract removal vary from $450 to $2800." A goal of PPS was to pay similar prices for similar products.

A third factor was that it was difficult to demonstrate the effect on health status of the growth in expenditures for acute care services. Many studies conducted in this period showed that increased expenditures on acute care services did little to improve overall health status. In the book Who Shall Live, Victor Fuchs argued that prevention and good personal habits are better predictors of health status than expenditures on medical care. He pointed out, for example, that residents of Utah are healthier than residents of Nevada because of differences in life style, although medical expenditures per capita are actually higher in Nevada.

Cost Containment: When Have We Gone Too Far?

Given the history of health policy, the danger of an over-response in the direction of cost containment is quite apparent. This is especially likely given the federal commitment to reduce the budget deficit. Indicators are needed to alert us when we have gone too far in controlling health care costs. These indicators should also suggest when the allocation of resources to individual providers can lead to adverse outcomes.

In order for the indicators to be useful to policymakers, they must have certain characteristics. They must be "leading" indicators in the sense that they will alert policymakers before the problem becomes severe. An indicator that will only measure changes several years after they occur may lead to the continuation of current policies even if they have become obsolete or destructive. This can happen because of delays in data collection or because it takes time for some problems to become apparent. For whatever reason, delay could lead to a continuation of health care policies years after they should be modified.

A second ideal characteristic of an indicator used to monitor quality of care under PPS is that they should link clearly payment policies to adverse outcome. Health outcomes are generally associated with a myriad of factors, and for the indicator to be truly effective and useful, it must show a direct relationship between payment policies and outcome.

Finally, the indicator must be easily understood by policymakers and the general public. The share of the GNP devoted to health care is an example of a simple indicator that is frequently used to demonstrate rising health care costs. Indicators must be meaningful to Congressmen, governors, business executives, the media, and the public in order to be truly effective in changing public perceptions. Sophisticated measures are not always useful in the public policy debate.

Specific Indicators

In this section I would like to suggest specific indicators that can be used to monitor outcomes that also meet the constraints mentioned earlier. I will describe the available data on each indicator. In order to assist the presentation I have grouped the indicators into three categories: quality of care, access to care, and change in the mission of the hospital.

Quality

The classic methodology for measuring quality of care is to examine the structure, process, and outcome of a visit. Most researchers suggest that all three measures need to be examined in order to get a comprehensive picture of the quality of care provided by an individual provider. However, structure and process measures generally require very expensive data collection and may not be easily understood by the general public. Outcome measures are frequently the easiest to collect and are generally the most persuasive to the general public.

Two outcome measures that are readily available to measure quality of care are mortality rates and hospital readmission rates. Mortality rates could be measured either during the hospital visit or up to 30 days post-hospital discharge. An increase in either indicator might indicate that quality of care has declined. Both inpatient mortality rates and readmission rates are available from the Medicare data base and can be studied longitudinally.

The only data I have available suggest that readmission rates have not increased since the passage of PPS. An article Earl Steinberg, M.D., and I published in the New England Journal of Medicine demonstrated that from 1974-77 there was a 22.5 percent probability that Medicare patients discharged from an acute care hospital would be readmitted within 60 days. Data suggest that hospital readmission rates have remained stable since the passage of PPS. I would strongly support, however, the increased review by PROs of readmissions for as long as 60 days. Our studies suggest that readmissions within 60 days can be linked to poor quality care.

Using either of these indicators as measures of quality of care presents problems. First, it is difficult to obtain accurate measures of each variable. For example, inpatient mortality rates published recently by HCFA require further adjustments for health status before they are useful measures of quality of care.

Second and more important than refining the methodology is the difficulty in establishing the link between payment reform and adverse outcomes. For example, an increase in inpatient mortality rates could be the result of the spread of surgery into outpatient settings. If simpler surgery could be performed on an outpatient basis, this would cause an overall increase in the severity of inpatients; the increase in inpatient mortality rate would not indicate a quality problem attributable to cost containment but a change in the severity of illness of hospital inpatients. Similarly, if the readmission rate increased because of a change in medical practice, then an increase in readmission rates would not necessarily be an indicator of the adverse effect of cost containment.

The most apparent effect of the prospective payment system has been the decline in average length of stay. It has led many analysts to conclude that patients are being discharged "sicker and quicker." However, this decline began prior to the passage of PPS; thus the decline in lengths of stay may not be attributable exclusively to PPS. Additionally, average lengths of stay on the East Coast are now equal to pre-PPS lengths of stay on the West Coast, and I know of no one arguing that West Cost patients were discharged inappropriately before 1983. These facts illustrate that measuring length of stay may not be an appropriate method of assessing quality.

The importance of the "sicker and quicker" phenomenon is in its implications for post-discharge health status. There is evidence that suggests that post-hospital support services are not yet in place to substitute for inpatient days. Unfortunately, very little is known about post discharge outcomes. It is necessary for the government to begin collecting data on Medicare patients' post-hospitalization health care needs in order to assess the true impacts of PPS. Work similar to the Northwest Oregon Health Systems Agency needs to be carried out on a national basis.

Access

The National Center for Health Statistics routinely collects a variety of measures of access to care. They are particularly useful in describing the characteristics of individuals who have poor access to medical care. In order to describe the outcomes of cost containment, however, a different set of indicators may be necessary. These indicators would be more directly related to payment policies. Three indicators--hospital closure, patient transfers, and patients being denied specific services--are promising candidates.

When the PPS legislation was originally passed, there were predictions that many hospitals would close and that patients would have to travel much further to receive hospital care. Recent data suggest that the number of closures has not increased substantially above historical rates. In 1985, 49 community hospitals closed compared to an annual average from 1980 to 1984 of 33 hospitals--a difference within normal statistical variation.

A second prediction was that the rate of transfer of indigent patients would increase substantially. Studies of public hospital admission patterns suggest that the number of transfers has increased. Although this data does not demonstrate a national trend, the number of transfers to D.C. General Hospital increased from 169 in 1981 to almost 1000 in 1984, and the number of transfers to Cook County increased from 1295 in 1980 to 6769 in 1983. Additional data should be collected to gain a national perspective on this phenomenon. Data from the pre-PPS period suggests that 2.2 percent of Medicare beneficiaries were transferred during their hospitalization.

It is difficult, however, to link PPS to these changes. First it should be recognized that the rate of transfers in the public hospitals began to increase prior to the implementation of PPS. In addition, federal policy toward the payment of bad debts incurred by non-Medicare beneficiaries has not changed. Medicare has never permitted Medicare funds to be used to pay the bad debts of non-Medicare patients. Equally important is that Congress has already begun to respond to the problem of transferring indigent patients. The Consolidated Omnibus Budget Reconciliation Act of 1985

(COBRA) includes a provision requiring any hospital participating in the Medicare program that has an emergency department to perform a medical screening examination on any patient who requests it to determine whether the patient has an emergency medical condition. A hospital may not transfer an unstable patient unless the patient requests the transfer or a physician certifies that the medical services offered at the other facility outweigh the risks associated with the patient's transfer and the receiving hospital has agreed to accept the transfer.

A third indicator of access is that certain patients may be denied treatment if they require expensive services. Patients requiring high cost technologies that do not have their own DRGs are especially vulnerable. In a study Earl Steinberg and I did at Johns Hopkins and several other hospitals, we found that patients requiring total parenteral nutrition (TPN) were much more expensive to treat than patients within the same DRG who did not require TPN. The difference in charges is quite substantial--averaging approximately $30,000 per patient. Since approximately 2 percent of Medicare beneficiaries require TPN, the cost to a hospital can be substantial. As an economist, I would predict that this unreimbursed cost would be a powerful economic incentive to lower utilization of TPN services. However, our discussions with physicians from the Association for Parenteral and Enteral Nutrition (ASPEN) suggest that the number of patients receiving TPN is increasing, which is a result contrary to our economic projections. This suggests that hospitals are not denying services to certain high cost patients who require them.

A third way to measure the outcome of cost containment efforts is to examine the changing mission of hospitals. Aside from patient care, hospitals provide many services, including uncompensated care, biomedical research, and training of health professions. Traditionally, many of these services have not been self-supporting and have been funded using patient care revenues. They are in jeopardy if hospitals are not funded adequately. A simple indicator of whether the hospital can maintain these services may be the hospital's operating margin. Hospital administrators may argue "no margin no mission" while economists suggest that "there is no such thing as a free lunch," but the implications are the same: hospitals need an operating surplus in order to cross-subsidize their other products. Indications from both the Inspector General and the AHA panel indicators data suggest that operating margins are increasing.

Another area that might indicate whether hospitals missions are changing is the residency match. Residency programs are frequently perceived as costly activities requiring cross-subsidization from other revenue centers. If hospitals begin to change their missions they might reduce the number of residency slots, and therefore the ratio between available slots and applicants will decline. This would become especially important if the number of new slots were less than the number of graduates from U.S. medical schools, thereby denying a medical school graduate the ability to practice medicine. No change is perceptible in the long term trend in residency matching rates as the result of PPS (Table 1).

Summary

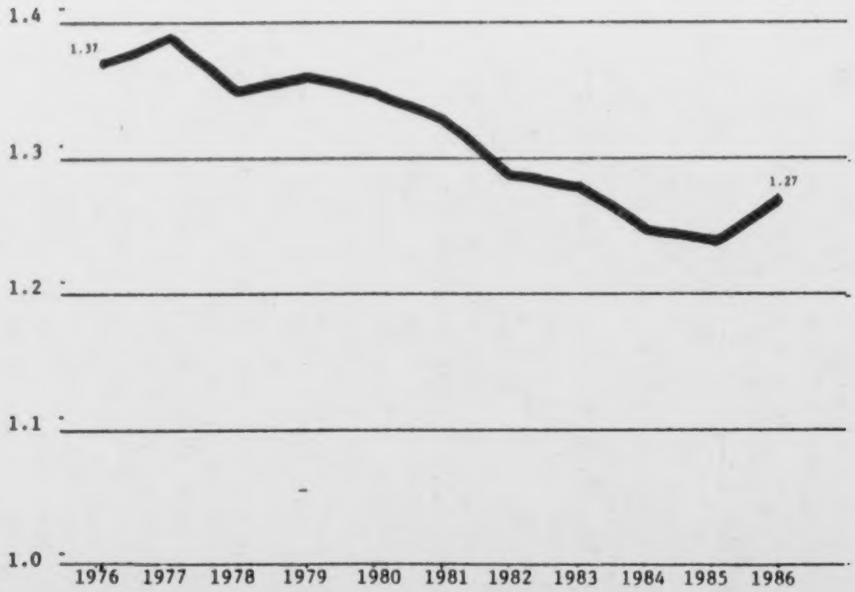
After years of debate, Congress has decided that cost containment and payment reform is necessary. Currently in place are the tools that enable Congress to set payment rates, and recent budgetary pressures have forced Congress to limit the rate of increase in provider payments. The methodology for determining payment levels to individual providers has been criticized for many reasons, including the absence of a adequate severity of illness measure.

Indicators that suggest that cost containment efforts have gone too far or that payment reform has affected quality of care are very difficult to develop. The ideal indicator would provide warning before the problem became serious, would link payment level and outcome, and would be easily understood by policymakers and the public. In my testimony I have examined certain indicators that measure quality of care, access to care, and the change in a mission of the hospital. None of the indicators suggest that quality of hospital care or access to hospital care has deteriorated substantially as a result of PPS. The one possible exception is patient dumping, which may have been exacerbated by PPS, although the phenomenon began prior to PPS. This is not meant to imply that PPS could not or even has not led to adverse outcomes. The problem is that our indicators are not able to accurately measure the effect of payment policies.

Thank you. I would be glad to answer any questions.

TABLE 1

AVAILABLE RESIDENCY SLOTS PER GRADUATING STUDENT
FROM U.S. MEDICAL SCHOOL



Senator **Durenberger**. Can I get some terminology down? What I want to go after is what happens when they leave the acute care setting, and we can call it subacute. Some of us will understand that. We can call it transitional. We can put it in the context of this "continuum of care."

But I wonder if there is an agreed terminology about what we mean? I mean, Cynthia, you talked about transitional and subacute; and I just read it through once and didn't go back and try to distinguish. Maybe your study was the most specific on this. Can you help me to just get the terminology down?

Ms. **Polich**. There is no agreed-upon terminology. There are a variety of terms used. Subacute care, transitional care are two of the most common used terms. These terms describe a level of care that is provided after the patient is no longer acute, which is fairly well defined in regulations, but still need some kind of care before they have totally recuperated.

That kind of care can be provided in a variety of settings. It is provided by hospitals. It is provided by nursing homes. It is provided by home care agencies, by informal care-givers, family members. Generally speaking, there is tremendous overlap. It can be provided within the long-term care system. Medicaid may pay for this care through its long-term care expenditures. Swing-bed provisions pay for this kind of care. Medicare-certified SNF's pay for it. This indicates a great deal of variation, and again, it varies tremendously from State to State, depending upon what their strategy has been in trying to fund or provide that kind of service.

So, there really is no clear definition.

Senator **Durenberger**. All right, but it is a transition from sick to well. That might be one way to look at it.

Ms. **Polich**. Exactly. And transitional care, or subacute care, is generally less expensive than acute care.

Senator **Durenberger**. And it is a series of subacute services, assuming that a hospital is in the acute care business and all other so-called settings are subacute. Is there any disagreement on that? Mr. Goldwyn?

Mr. **Goldwyn**. Not to disagree. In Portland, the issue has basically been more specific and not quite so conceptually general. There are particular groups of patients in a hospital for example who are no longer acute, but will be going to rehabilitation in a few days. Do they transfer them out and then bring them back? There are patients who are no longer acute who will be imminently terminal; but the acute care won't change that. Do you transfer them out, with 24 or 48 hours presumed to live—or do you keep them in the hospital for humanitarian kind of reasons?

Patients who are from out of town referred to a tertiary care urban setting. Do you transfer them to a nearby nursing home when the family wants to wait until there is a transfer to the nursing home back home in the small rural community?

Those are the kinds of specific categories of patients that seem to cause the most problem, at least in our community, in terms of the hospital saying we need some reimbursement to care for these people for the next few days, even though they are not acute.

So, that is kind of specific as to how that conceptual structure would apply.

Senator **Durenberger**. Is there anyone here who disagrees with the thesis that, if there were ways to pay for subacute care or transitional care, that we wouldn't be having a hearing that was focusing on early discharges? In other words, one of our problems here is that when we made the decision in early 1983 to go to a PPS system, we said we are not going to let the hospitals charge over and above the PPS amount.

And even if you want to pay them money to stay in that bed, you can't do it because we were afraid the hospitals would rip the system off and take advantage of these folks and all that sort of thing. So, it appears that one of our problems is that we don't have a kind of a continuum; and even if it is there, it is there for those who can't afford it or something like that. And the reimbursement system, as John Heinz said earlier—I think he is contemplating some legislation—the reimbursement systems here are just not keeping up with the realities.

Now, whether we make a leap to a capitated system where Medicare pays $1 or a set of dollars to somebody, or whether we have some variety of supplemental post-Medicare or whatever, wouldn't that give us—if we moved in that direction—wouldn't that do a lot for us in this whole quality of care area?

Ms. **Polich**. I would agree with that. I think that the one thing we want to avoid are situations where we encourage the hospitals to keep people inappropriately as well as discharge them inappropriately. A transitional level of care provided to people who are no longer acute, is not only less expensive, but also is a much more appropriate setting for those people than an acute inpatient hospitalization.

Dr. **Chassin**. Two comments on that, on the issue of transitional care. One is that to emphasize some of the points that have been made earlier in a concise way that there is enormous geographic variability on the availability of appropriate postdischarge care, not only on a State basis but on a communitywide basis; and to try and homogenize that with regulation, I think, would be a mistake because individual communities have enormous variability in their access to specific kinds of posthospital care.

The second is that providing another level of care is risky in that, in addition to the planned or hoped-for outcome that patients will be transferred from acute care down to a subacute level, you also have the problem of transferring patients up from a lower level of care to that now more intensive level of care. And in almost every instance where another level of care has been provided, attracting patients who can use that level of care from a lower level of care has been the predominant factor and it has resulted in increased costs.

So, it has to be introduced—if we are going to introduce another level of care—very carefully.

Senator **Durenberger**. John Chafee?

Senator **Chafee**. Thank you, Mr. Chairman. I would like to go over your statement, Dr. Chassin. Your conclusion is that the most striking characteristic of our knowledge concerning the quality of care provided to Medicare beneficiaries is how little there is. In other words, you set out a whole series of "such and such might happen in the hospitals and the discharges and the treatment of those who are sicker," but then you go on to say, "but we don't have any data to confirm that."

So, can you report to us now that we really don't know what the effect of prospective reimbursement has been?

Dr. **CHASSIN**. That is correct. We really don't know the impact of prospective payment.

Senator **CHAFEE**. And I must say I was intrigued with the geographic differences in the use of the health care services.

It seems to me that our country is essentially uniform because of the massive transfer of population—the statistics are that one-third of Americans move every year. That doesn't mean necessarily that they move out of State, but Los Angeles looks like Phoenix, which looks like Levittown, Long Island. And they all eat the same foods, ghastly as they are in many instances; and so, I can understand why Utah might be healthier than Nevada. Did you point that out?

Dr. **CHASSIN**. That wasn't in my testimony.

Senator **CHAFEE**. Well, Dr. Anderson did. In Utah, because of tne religious background of the people—they don't smoke and they don't drink—and presumably they keep themselves more fit than the people in Nevada who are busy at the gaming tables. [Laughter.]

So, your conclusion is we don't know? Is that what you said?

Dr. **CHASSIN**. We know that there are large geographic differences.

Senator **CHAFEE**. But I mean overall. We don't know what is the effect of prospective reimbursement. Dr. Anderson, it seems to me you are saying about the same thing.

Dr. **ANDERSON**. Correct.

Senator **CHAFEE**. That we just plain don't know. Now, you are working with Dr. Chassin on your studies, and you are halfway through some of them, but I really look forward to those studies because they are going to give us the answers to the questions we have here. The information we have may be anecdotal, but as politicians we have the feeling from our constituents that people are being discharged from the hospitals too soon; but you can't corroborate that.

Now, Dr. Anderson raises the point of a particular type of care that, if you give it to the patient, it costs $30,000 extra; and if you don't, you save the $30,000. Yet the statistics show that indeed this type of care has been increased.

Dr. **ANDERSON**. Correct.

Senator **CHAFEE**. It's TPN services.

Dr. **ANDERSON**. Total parenteral nutrition.

Senator **CHAFEE**. Which is curious. So, that suggests, as you say, that the hospitals are not denying those services to certain high-cost patients.

Dr. **ANDERSON**. To the extent that we have talked to physicians and to the extent that we have talked to the industry, the growth rates in this particular service have continued as they did prior to the passage of PPS, contrary to what I would have thought as an economist would have happened.

Senator **CHAFEE**. It seems to me that again you come to somewhat the same conclusion as Dr. Chassin, that we don't know.

Dr. **ANDERSON**. Yes.

Senator **Chafee**. Then all of these factors could possibly be present. On the other side, there are factors that work the other way. One of the concerns we had, I can remember when we passed this legislation in 1983, was about the closure of rural hospitals. Your information indicates that the closures continued at the historic rate that existed in the 1970's. It hasn't changed at all. Maybe it is a little bit higher.

Dr. **Anderson**. My concern is that we don't have quality measures and potentially we won't have quality measures for another 2 or 3 years until we get Dr. Chassin's and other studies done; but we still have to make decisions in the next 2 years over the rate of increase in Medicare expenditures and other changes. And the lack of data will mean that the people who want to make cuts can make cuts easier.

Senator **Chafee**. What would you suggest we do?

Dr. **Anderson**. I think that you want to pay attention to groups like the Prospective Payment Assessment Commission, which has set a little bit above the 2-percent increase in Medicare expenditures and not use the one-half of 1 percent increase for example. Just that one simple change.

Senator **Chafee**. Now, some suggest that we ought to have legislation to request more specific information, but we can't get it any faster. You can't go any faster than you are, can you, Dr. Chassin?

Dr. **Chassin**. Not in the research. No. But I would suggest that—let me make clear that my statement that we don't know what the impact of prospective payment has been on quality does not mean that I don't believe that there is poor quality care. There is poor quality care. It existed before prospective payment, and we ought to set up systems to find it and to correct it, regardless of whether it has increased or decreased under prospective payment.

Senator **Chafee**. Oh, well, no one would argue with that, but as you point out, there was poor quality care long before PPS came along.

Dr. **Chassin**. Correct.

Senator **Chafee**. Thank you for these statements which are extremely interesting, although a little frustrating. When we are finished, we will know a lot more facts, but we really won't know the conclusions.

Senator **Durenberger**. Thank you, John. John Heinz?

Senator **Heinz**. Mr. Chairman, thank you. Let me just follow up with Dr. Chassin. As I understand your testimony, what you are saying is that one of the adjustments to the prospective payment system is that hospitals are finding ways to cut back on certain kinds of services so that the costs of each stay are less costly. As I understood your testimony, you mentioned that there is a trend in many institutions to limit pharmacy services, to reduce the available scope of drugs, often expensive antibiotics. Have I got that right so far?

Dr. **Chassin**. That is one possible way that hospitals have tried to cut back on costs.

Senator **Chafee**. I don't think you said it has happened. I think you said it could happen.

Dr. **Chassin**. There are some hospitals that have done that. I don't know——

Senator HEINZ. That is what I was going to ask. What are the data?

Dr. CHASSIN. There are no data that suggest that this is happening at any greater rate after PPS than before PPS; but it certainly is one of the steps, as an anecdotal piece of information, that hospitals have been taking. I don't have any data on incidence or frequency. I don't think anybody does.

Senator HEINZ. But you do know of some hospitals that are doing it?

Dr. CHASSIN. Yes.

Senator HEINZ. What about in other areas, such as radiologic or therapeutic services?

Dr. CHASSIN. There is some data on the spread of magnetic resonance imaging scanners and the new generation CT scanners, suggesting that it is somewhat spreading less rapidly than CT scanners did before PPS; but again, that has some problems in interpreting it as a direct effect of PPS, although one could put that interpretation on it.

Senator HEINZ. Very well. Dr. Anderson, I want to ask you a question. As you know, in the Medicare Quality Protection Act, we have PRO's review hospital readmissions within 30 days. You are advocating 60 days' review.

Dr. ANDERSON. Correct.

Senator HEINZ. A lot of people say you don't need to do that. You don't need to do even 30 days. Why do you think 60 days is better than 30 days?

Dr. ANDERSON. I think you are getting into a gray area between 30 and 60, but when we did some analysis on the characteristics of the patients who were readmitted both within 30 and 60 days, we found fairly strong similarities. We found that there were substantial differences between what types of hospitals they were discharged from and other factors like that. So, we thought that there was some characterstics among patients for both 30 and 60 days and the characteristics of the hospitals and probably, therefore, the characteristics of quality of care that occurred in those hospitals.

And we thought that a 60-day limit or control was necessary.

Senator HEINZ. What would you say to those people who say that 15 days is adequate?

Dr. ANDERSON. I think that 60 is a more appropriate number than 15 or even 30.

Senator HEINZ. Why? For those people who are advocating 15 days, what would you explain to them that they are missing? Why is it important to have or not have——

Dr. ANDERSON. There are circumstances which occur within the hospital during that stay which mean that the person will be readmitted, not necessarily within 15 days, but up to 60 days. Certain characteristics that occur during that discharge which will result in higher readmission rates all the way up to 60 days.

Senator HEINZ. Like what?

Dr. ANDERSON. It varies by type of hospital. It varies by the type of physician, the type of illness which the patient has.

Senator HEINZ. Do you have any data?

Dr. **Anderson**. Yes, we have a whole series of data. We have published both in the New England Journal of Medicine and the Journal Inquiry.

Senator **Heinz**. Would you please make those available for the record?

Dr. **Anderson**. Sure.

[The prepared information follows:]

Gerard F. Anderson
Earl P. Steinberg

Predicting Hospital Readmissions in the Medicare Population

Using a nationally random sample of Medicare beneficiaries, we developed a multivariate logistic model that identified a series of factors that predict readmission to an acute care hospital within 60 days of discharge. Our regression results show that 10 variables are statistically significant predictors of readmissions, with the patient's disease history and diagnosis among the best predictors. Our results can be used by peer review organizations to evaluate the quality of care provided by different hospitals as well as by physicians and social workers to improve discharge planning.

Readmissions to acute care hospitals occur frequently,[1] particularly in the case of elderly patients. We demonstrated previously, for example, that more than 22% of Medicare discharges between 1974 and 1977 were followed by a readmission within 60 days of discharge.[2] The cost of such readmissions is substantial. Between 1974 and 1977 Medicare spent almost $2.5 billion annually on readmissions that occurred within 60 days following discharge. After adjustments are made for inflation and trends in Medicare admission rates, the cost to Medicare of such readmissions in 1984 may exceed $7.5 billion.[3] Expenditures could be even larger as a result of the economic incentives created by the Medicare Prospective Payment System.

Despite the financial impact of readmissions, little is known about the factors that influence readmission and no models exist that identify those patients who are most likely to be readmitted to an acute care hospital. Identification of risk factors for readmissions could be useful in several ways. First, knowledge of risk factors could be used to improve estimation of the probability that any given patient will be readmitted to the hospital. Such information could assist physicians and social service departments in discharge planning. To the extent that improved targeting of outpatient support services reduces readmissions to the hospital, hospitalization rates and costs could be lowered. Hospitals could also use readmission rates to monitor quality of care provided by individual physicians and to compare care at their hospital with that received at other hospitals. In addition, by helping to identify specific factors that place patients at increased risk for readmission, a readmission prediction model could be used by insurers, private corporations, unions, and health maintenance organizations in the development of specific programs that could reduce hospitalization rates.

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A readmission prediction model could also assist peer review organizations (PROs), which have been established by Congress and given responsibility for monitoring Medicare admission patterns under the new Prospective Payment System. Because the Prospective Payment System creates economic incentives that could lead to increased readmission rates,[4] the admission monitoring responsibilities of PROs take on greater importance. A readmission prediction model could help identify hospitals (or physicians) with abnormally high readmission rates that are not explained by case mix, location, or other factors. Hospitals identified as having abnormally high readmission rates could then examine the practices of individual physicians, the medical staff as a whole, or the social service department in an effort to identify strategies for reducing readmission rates and improving the quality of patient care.

In view of these potential benefits, we undertook an analysis of a number of demographic, clinical, and hospital characteristics to identify which factors are most predictive of readmission within 60 days following release from a hospital.

Methods

Data Base

The data we used to develop our readmission prediction model were derived from a 1% national random sample of all Medicare beneficiaries in the Medicare program at some time during the period 1974–1977. Beneficiaries who were in the program during this period but who died during it were included in the sample. After we excluded beneficiaries with end stage renal disease, our data set contained information on 270,266 beneficiaries and the 420,894 discharges they generated during 1974–1977. To obtain additional information about the characteristics of the hospitals where the patients received care, we merged the Medicare file with the American Hospital Association (AHA) Annual Survey of Hospitals.

Dependent Variable

We defined readmissions using a dichotomous variable that measured whether or not a patient was hospitalized during the 60 days following discharge from an acute care hospital. Our choice of 60 days for the definition of a readmission is somewhat arbitrary, although it does correspond to the spell-of-illness definition used by the Medicare program. Data limitations required us to count interhospital transfers as readmissions. Using the conservative assumption that an interhospital transfer occurred whenever a patient was readmitted within 24 hours of discharge to a hospital other than that from which he or she had been discharged, we demonstrated previously that at most, 2.2% of the Medicare discharges in our sample were likely to have been interhospital transfers.[5]

Independent Variables

We hypothesized that 20 variables influence the probability of readmission (see Table 1). Although our rationale for including most of the variables is straightforward, our methodology for creating some of the variables requires explanation. We derived data for variables 1–13 directly from the Medicare data file. We determined the number of discharges for the same disease in the 60 days prior to the incident hospitalization (variable 10) by comparing the three-digit International Classification of Diseases (ICD, eighth revision)[6] diagnostic code listed for the primary diagnosis for each hospitalization. We classified only exact matches as readmissions for the same disease.

Prior to analyzing the data, we classified each three-digit diagnostic code in the eighth revision of the ICD on the basis of clinical judgment into one of two categories: diseases that are likely to be characterized as self-limited versus diseases that are chronic or that may be characterized as recurrent. We then assigned the primary diagnosis for each hospitalization to one of these two categories based on this preestablished classification to form variable 14.[7] Variables 15–20 were based on data from the AHA Annual Survey of Hospitals.

Statistical Analysis

We performed univariate analyses to define the relation of each variable to the likelihood of readmission. We used the chi square test to assess statistical significance. We then tested all 20 variables in a multivariate logistic regression. Logistic regression is appropriate for analyzing dichotomous dependent variables and several independent discrete and continuous variables.[8] Discrete variables were given a value of 0 if absent and 1 if present. Nominal variables were valued as follows: sex (female = 0, male = 1) and race (white = 0, nonwhite = 1).

We performed the logistic regression in a stepwise fashion. Initially, we included all 20 independent variables in the analysis. We then eliminated variables one at a time, based on their level of statistical significance, until all remaining independent variables were statistically significant ($p < .01$).

We performed the analysis on a sample of 21,043 discharges, representing every 20th record beginning with record 10 from the rank ordering of records based on beneficiary Social Security number. This selection procedure ensured that no beneficiary would appear more than once in our sample except for the few individuals (10 out of 270,266) with more than 20 readmissions during our period of observation. We thus avoided problems with biased standard errors.

We assessed the magnitude of the impact of each variable, X_i, individually on the probability of readmission, after adjustment for all other variables in the analysis, by calculating the relative risk of readmission at one value of X_i compared with another. We estimated relative risk by $\exp [b_i(X_i^* - X_i)]$, where b_i is the estimated regression coefficient for the ith variable and X_i^* and X_i are two different values for the ith variable. We calculated relative risks at the mean value for all other variables in the equation.

We used a two-step process to estimate the probability of readmission for any Medicare beneficiary at the time of discharge. First, we multiplied the value of each variable included in the final model by its respective logistic regression coefficient and then added these weighted values to a constant term to produce a logistic sum, L. We then calculated the probability of readmission as $(1 + e^{-L})^{-1}$.

We validated the model by applying it to a second, nonoverlapping random sample of 10,522 discharges. For each of these 10,522 cases, we calculated a probability of readmission using the method described above. We then rank ordered cases on the basis of their estimated probability of readmission and classified them into deciles. We then compared estimated and actual probabilities of readmission within each decile and assessed agreement between the estimated and actual probabilities using a two-sided Wilcoxon test,[9] a standard technique used in biostatistics.

Table 1. Independent variables

A. Demographic

1. Age
2. Sex
3. Race
4. Disability status
5. Supplemental Medicaid coverage
6. Patient lives in Northeast
7. Patient lives in North Central
8. Patient lives in West

B. Clinical

9. No. of discharges in 60 days prior to admission
10. No. of discharges with same diagnosis in 60 days prior to admission
11. Surgery performed
12. Length of stay
13. Hospital reimbursement
14. Admission for nonchronic versus chronic disease

C. Hospital

15. Urban area
16. Community hospital
17. State or local hospital
18. For-profit hospital
19. Fewer than 100 beds
20. Teaching hospital

Results

Risk Factors for Readmission

For the initial sample of 21,043 discharges, we determined the univariate relationship between each of the 20 independent variables hypothesized to affect readmission rates and the likelihood of readmission within 60 days of discharge. The results are presented in Table 2. We then examined all 20 variables using logistic regressions performed on the sample. Of the 20 variables originally hypothesized to affect readmission rates, 10 were statistically significant ($p < .01$); see Table 3.

Significant clinical predictors included the number of discharges in the 60 days prior to admission, whether the primary diagnosis was classified as a nonchronic or a chronic disease,

Table 2. Univariate associations of independent variables and readmission

Variable	Cases readmitted (n = 4,610)	Cases not readmitted (n = 16,433)	p value
1. Age (years)	72.3	73.2	<.0001
2. Sex (% male)	50.0	44.5	<.0001
3. Race (% white)	10.3	10.0	.57
4. Disability status (% disabled)	11.3	8.9	<.0001
5. Supplemental Medicaid coverage (%)	15.8	12.8	<.0001
6. Lives in Northeast (%)	20.1	22.4	<.005
7. Lives in North Central (%)	28.1	29.2	.14
8. Lives in West (%)	16.4	14.4	<.001
9. Discharges in 60 days prior to admission (mean per case)	.45	.23	<.0001
10. Discharges with same diagnosis prior to admission (mean per case)	.14	.05	<.0001
11. Surgery performed (%)	25.4	32.6	<.0001
12. Length of stay (mean days per case)	14.1	13.1	.27
13. Hospital reimbursement (mean $ per case)	1,450.5	1,423.3	.35
14. Admission for nonchronic disease (%)	14.7	20.7	<.0001
15. Hospital in urban area (%)	67.2	71.2	<.0001
16. Community hospital (%)	97.8	97.9	.67
17. State or local hospital (%)	22.9	20.0	<.0001
18. For-profit hospital (%)	5.7	5.4	.41
19. Hospital with <100 beds (%)	19.9	16.4	<.0001
20. Teaching hospital (%)	15.8	16.0	.83

and whether surgery was performed. The separation of diagnoses into chronic and nonchronic categories thus appears to be a useful distinction in predicting readmissions. Interestingly, once the number of discharges in the 60 days prior to admission was taken into account, the number of discharges with the same diagnosis in the 60 days prior to admission did not add significantly to the ability to predict a readmission in the 60 days following discharge.

Other clinical variables such as length of hospital stay did not contribute significantly to the predictive power of the model in the presence of the other variables. In interpreting the length-of-stay result, however, it should be recognized that we did not control for diagnosis beyond considering whether a disease process was likely to be self-limited or chronic. Thus, length of stay could prove to be an important predictor of subsequent readmission if analyses are performed within specific disease categories such as asthma or myocardial infarction.

Of the demographic variables, age, sex, race, and eligibility for supplemental Medicaid coverage emerged as significant predictors. After controlling for other variables, the region of

Table 3. Final prediction model: Statistically significant variables in logistic regression (n = 21,043)

Variable name	Coefficient	F value	p value
1. Age	−.00480	8.2587	<.01
2. Sex	.10908	9.8697	<.01
3. Race	−.14732	7.0790	<.01
4. Supplemental Medicaid coverage	.21179	18.4737	<.01
5. No. of discharges in 60 days prior to admission	.46509	294.1105	<.01
6. Admission for self-limited, nonchronic disease	−.34245	50.4367	<.01
7. Surgery performed	−.33536	67.2902	<.01
8. Reimbursement	.00005	21.6499	<.01
9. Hospital in urban area	−.19647	20.5016	<.01
10. Hospital with <100 beds	.16399	10.3027	<.01
11. Constant	−.16840		

Table 4. Odds ratios for independent variables

Variable name	Variable value	Relative risk of readmission within 60 days (odds ratio)	95% confidence interval for odds ratio
Age	10 years older	.95	(.92, .98)
Sex	Male	1.12	(1.04, 1.20)
Race	Nonwhite	.86	(.77, .95)
Supplemental Medicaid coverage	Medicaid	1.24	(1.12, 1.36)
No. of discharges in 60 days prior to admission	One prior admission	1.59	(1.51, 1.67)
Admission for self-limited, nonchronic disease	Self-limited disease	.71	(.64, .78)
Surgery performed	Surgery	.71	(.66, .76)
Reimbursement	Additional $1,000	1.05	(1.03, 1.07)
Hospitalized in urban area	Urban hospital	.82	(.75, .89)
Hospital with <100 beds	100 beds	1.18	(1.06, 1.30)

the country where a patient lived, and whether he or she qualified for Medicare on the basis of disability or age alone, did not add significantly to the ability to predict readmission. The fact that region of the country did not emerge as a significant predictor is somewhat surprising given the existence of wide variations in medical practice in the United States[10] and previous research suggesting marked regional variations in Medicare admission rates.[11] Nonetheless, our findings suggest that once other variables are controlled for, the region of the country in which a Medicare beneficiary lives is not a good predictor of readmission within 60 days of discharge.

Only two hospital characteristics—urban versus rural location, and bed size—were significant predictors. Patients hospitalized in urban areas were less likely to be readmitted than were those in rural areas, a finding that could be the result of better patient referral mechanisms or more social services available in urban hospitals. Patients discharged from small hospitals were more likely to be readmitted than were those discharged from large hospitals. Further data are required to assess whether this difference is a reflection of differences in quality of care between different-sized hospitals. Patients discharged from community, state or local, for-profit, or teaching hospitals were no more likely to be readmitted than were those discharged from their counterparts. The lack of a difference in readmission rates between teaching and nonteaching hospitals is surprising given the more complex case mix that is generally seen in teaching hospitals.

The final statistically significant variable is Medicare reimbursement for the incident admission, which was positively associated with readmission rates. This finding may reflect an association between hospital charges and case complexity.

Relative Risk

To obtain some insight into the magnitude of the impact each statistically significant independent variable had on the probability that a patient would be readmitted within 60 days, we calculated the relative risk of readmission (and its 95% confidence interval) for each variable. We calculated relative risks at the mean value for all other variables. The results are shown in Table 4 and can be interpreted as follows. The value of 1.59 listed for the number of discharges in the 60 days prior to admission means that, after adjustments are made for all other variables in the analysis, a Medicare patient who has one discharge in the 60 days prior to admission is 1.59 times more likely to be readmitted within 60 days than is a Medicare patient with zero discharges in the 60 days prior to admission. Similarly, the value of .71 listed for surgery performed implies that a patient who undergoes surgery has a risk of readmission that is .71 times that of a patient who does not undergo surgery. The four variables that had the greatest impact on the probability of readmission were the number of discharges in the 60 days prior to admission, whether the primary diagnosis was chronic or nonchronic, whether surgery was performed,

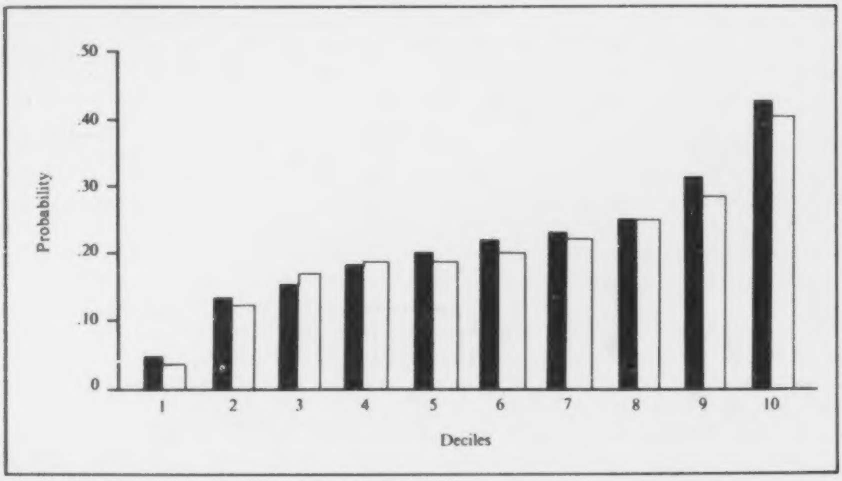

Figure 1. Predicted (solid columns) versus actual (open columns) probability of readmission cases (n = 10,522), rank ordered on the basis of predicted probability and grouped into deciles

and eligibility for supplemental Medicaid coverage.

Validation

To determine a model's value in predicting an outcome of interest, it is important to validate it by applying it to an independent population. We therefore tested our model on a second random sample of 10,522 discharges. We compared estimated and actual probabilities of readmission within deciles derived from a rank ordering of cases based on predicted probability of readmission. The results are shown in Figure 1. Predicted and actual readmission rates were very close. Agreement between them was statistically significant ($p < .05$) when assessed using a two-sided Wilcoxon test.

Discussion

By applying multivariate logistic regression analysis to a large random sample of Medicare discharges between 1974 and 1977, we identified a number of risk factors for readmission within the 60 days following discharge and developed and validated a readmission prediction model that employs data that are readily available at the time of a patient's discharge. The most important predictive variables that emerge from our analysis are clinical (the number of discharges in the 60 days prior to admission, whether the primary diagnosis was classified as chronic or nonchronic, and whether surgery was performed) and coverage related (eligibility for supplemental Medicaid coverage). Other variables that are statistically significant but less powerful predictors of readmission include the patient's age, sex, and race, the amount of Medicare reimbursement to the hospital, and the location (urban versus rural) and size of the discharging hospital.

Before we discuss the implications of our results, three methodologic issues should be addressed. First, we chose to define a readmission as an admission to an acute care hospital within 60 days following a discharge. Our choice of 60 days was somewhat arbitrary, although it does correspond to the spell-of-illness definition used by the Medicare program; it also seems reasonable given our interest in identifying admissions that might be prevented by changes in patient management during or soon after a hospitalization. Although we have not done so, alternative models can be developed using 5-, 30-, or even 365-day definitions of readmission.

Second, we counted interhospital transfers, which typically involve an admission within 24 hours of a discharge, as readmissions in our study. Because such transfers are qualitatively different from other readmissions, an argument can be made for not considering them as readmissions. Because previous analysis has demonstrated that only 2.2% of the Medicare discharges in our sample were likely to have been readmissions,[12] however, it is unlikely that inclusion of transfers within our definition of readmissions had a major impact on our results.

The final methodologic issue relates to our classification of diseases into chronic and nonchronic categories. In many instances a disease could reasonably have been classified as either chronic or nonchronic, so we had to make a somewhat arbitrary classification decision. Issue could thus be taken with many of our classification decisions. The classification scheme we developed did turn out to help predict readmissions, however, and is available to those who are interested in it.

The most important applications of our readmission prediction model lie in its use in identifying hospitals with high readmission rates that are not explainable by case-mix demographics or other correlates of risk of readmission, and in identifying those patients who are most likely to be readmitted within 60 days of discharge. In the former application, the model should prove useful to PROs charged with responsibility for monitoring readmission rates under Medicare's Prospective Payment System. In the latter application, the model could be used by physicians, social service departments, and utilization review committees trying to improve and monitor the quality of patient care. Attention to the eight factors contained in the model, for example, can result in a range of predicted probability of readmission for an individual patient from as low as .06 to greater than .90.

Hospitals would be wise to concentrate their initial readmission reduction efforts on the 10% to 25% of cases with the highest predicted risk of readmission. Given the expense associated with Medicare readmissions, tremendous savings for the Medicare program could result from only a small reduction in the Medicare readmission rate. If the number of readmissions within 60 days in the Medicare program could be reduced by just 10% (i.e., from 22% to 20%), for example, Medicare payments for acute care hospital services could be reduced by 2.3%.[13] For 1984, such a reduction would have resulted in savings of $1.2 billion.

Providers operating under a capitated system of payment could similarly achieve savings through a reduction in readmission rates. HMOs, for example, which have been shown to achieve savings primarily by controlling admission rates,[14] could use a readmission prediction model such as ours in conjunction with a program designed to modify determinants of readmission to achieve both short-term savings and a long-term competitive advantage.

Future Research

Our analysis suggests a number of areas for further research. First, the extent to which the predictive power of the model could be improved through consideration of such additional factors as a patient's marital status or living situation, which are not available in the Medicare file, needs to be explored. It would also be interesting to evaluate data on the type of setting to which a patient is discharged. Of particular interest is whether discharge to a nursing home or follow-up by a home health agency influences readmission rates.

Second, inclusion in the model of more specific diagnostic information than we have used here should be undertaken. Separate readmission prediction models could be developed, for example, for the 10 most common Medicare discharge diagnoses. Additional research is also necessary to understand why urban hospitals have significantly lower readmission rates than rural hospitals and why smaller hospitals have significantly higher readmission rates than larger hospitals. Similar models could be developed for other patient populations, including those covered by Blue Cross Plans, Medicaid, and commercial insurers and for large groups of people employed by various types of corporations.

Finally, the practical benefits of our model, particularly in improving discharge planning, need to be evaluated in an on-site trial. Such a demonstration project would indicate the extent to which the model could actually be used to reduce readmission rates.

Notes

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SPECIAL ARTICLE

HOSPITAL READMISSIONS IN THE MEDICARE POPULATION

Gerard F. Anderson, Ph.D., and Earl P. Steinberg, M.D., M.P.P.

Abstract In order to examine the proportion of Medicare expenditures attributable to repeated admissions to the hospital, we assessed the frequency with which 270,266 randomly selected Medicare beneficiaries were readmitted after hospital discharge between 1974 and 1977. Twenty-two per cent of Medicare hospitalizations were followed by a readmission within 60 days of discharge. Medicare spent over $2.5 billion per year (24 per cent of Medicare inpatient expenditures) on such readmissions between 1974 and 1977. Analogous expenditures in 1984 could approach $8 billion.

Even a small decrease in the readmission rate could result in substantial savings for the Medicare program. The recently enacted prospective-payment legislation, however, creates economic incentives that could increase readmission rates. Attempts by professional review organizations or others to develop hospital readmission profiles will need to control for patient and hospital characteristics that are correlated with the likelihood of readmission. Further study of such characteristics could help identify high-risk patient groups for whom increased outpatient supports might prove cost effective. (N Engl J Med 1984; 311:1349-53.)

RISING heath-care costs and, more recently, federal deficits have generated great interest in identifying changes in medical-practice patterns or financing methods that might decrease federal health-care costs without eroding the quality of care or patients' access to it. In meeting this challenge, it is essential that the determinants of Medicare expenditures be more fully assessed.

Previous studies of acute-care hospitalizations have found that high-cost users of medical care are more likely to be persons with chronic medical problems who are repeatedly admitted to the hospital than those with single, cost-intensive hospital stays.[1,2] In the

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study by Zook and Moore,[7] persons over 65 years of age were found to be disproportionately represented in the high-cost group.

In an effort to characterize more fully the proportion of Medicare expenditures attributable to repeated admissions to the hospital, we undertook a study of hospital readmission rates among beneficiaries in the Medicare program between 1974 and 1977, the most recent years for which longitudinal data were available.

METHODS

The data used to examine these issues were derived from a 1 per cent random sample of all Medicare beneficiaries who were in the Medicare program at some time during the period 1974 to 1977. Beneficiaries who were in the program but who died during this period were included in the sample. After we excluded beneficiaries with end-stage renal disease, our data set contained information about 270,266 beneficiaries and the 420,903 discharges generated by them during the period 1974 to 1977. The data set included information about the age, race, and sex of each beneficiary, as well as the principal diagnosis, length of stay, total Medicare reimbursement, and a hospital identifier for each patient admission.

The Medicare data set was merged with the results of the American Hospital Association's Annual Survey of Hospitals to obtain information about the characteristics of the hospitals in which patients received care. Data on the number of a hospital's beds, its teaching status, and the region of the country in which it was situated were included.

We defined a readmission as having occurred when a patient was discharged from an acute-care hospital and readmitted to the same or a different acute-care hospital within 60 days of discharge. Data were also analyzed with a readmission defined as an admission within 365, 30, or 5 days of discharge. We defined an interhospital transfer as having occurred when a patient was readmitted within 24 hours of discharge to a hospital other than that from which he or she had been discharged. To avoid underestimation of readmission rates, we included as "initial" discharges only those that occurred during the period 1974 to 1977, and we used data from 1978 to permit a full 365 days for observation of any readmissions that may have occurred.

The operational implications of our definition of readmissions and transfers can be illustrated by the following example. Assume that patient Jones is admitted to hospital X on January 1, 1974, discharged on January 10, 1974, admitted to hospital Y on January 10, 1974, discharged on January 28, 1974, admitted to hospital X on February 1, 1974, and that he dies in hospital X on February 10, 1974. According to our definitions, patient Jones had three admissions, two readmissions, and one interhospital transfer.

RESULTS

Dimensions of the Problem

Figure 1 demonstrates the frequency with which various percentages of the Medicare population were discharged from acute-care hospitals between 1974 and 1977, as well as the percentage of Medicare's inpatient expenses that were attributable to each group. It shows that Medicare inpatient expenditures were highly concentrated on a small percentage of beneficiaries who were discharged from the hospital more than once over this four-year period. The 23 per cent of Medicare beneficiaries who were discharged from an acute-care hospital more than once between 1974 and 1977, for example, accounted for 80 per cent of Medicare's inpatient hospital expenditures during that period. Almost 60 per cent (58.2 per cent) of

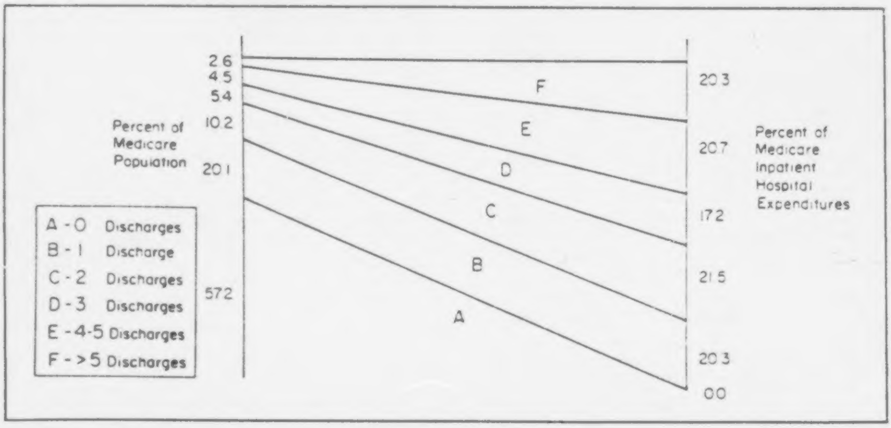

Figure 1. Medicare Inpatient Hospital Expenditures Attributable to Beneficiaries with Various Numbers of Discharges.

The graph shows the frequency with which various percentages of the Medicare population were discharged from an acute-care hospital between 1974 and 1977 and the percentage of Medicare's inpatient expenses attributable to each group. The percentage of Medicare beneficiaries in each group is identified on the left side of the figure, and the percentage of Medicare inpatient hospital expenditures attributable to each group is identified on the right. Both sides of the figure are drawn to scale, so that the width of a band on the left-hand margin reflects the percentage of Medicare beneficiaries in a group and the width of the same band on the right-hand margin reflects the percentage of inpatient expenditures attributable to the same group.

Medicare's inpatient expenditures were attributable to the 12.5 per cent of its beneficiaries who were discharged three or more times between 1974 and 1977, and over 20 per cent (20.3 per cent) of inpatient expenditures were attributable to the 2.6 per cent of beneficiaries who were discharged more than five times. Interestingly, the mean expenditure per hospitalization was relatively constant regardless of the number of times a beneficiary was discharged (Table 1).

Table 1. Mean Expenditure per Hospitalization for Medicare Discharges between 1974 and 1977.

No. of Discharges	Average Expenditure*
0	0
1	$1,316
2	$1,376
3	$1,280
4	$1,380
5	$1,359
>5	$1,248

*Average Medicare inpatient hospital expenditure per hospitalization in constant 1977 dollars.

To define more precisely the temporal relation between the repeated hospitalizations that occurred during this period, we examined the interval between discharges and readmissions among Medicare beneficiaries who had at least one discharge from an acute-care hospital between 1974 and 1977. Table 2 shows that 50 per cent of the Medicare discharges that occurred during this period were followed by a readmission within 365 days of discharge. Almost one fourth (22.5 per cent) of the Medicare discharges were followed by a readmission within 60 days of discharge, and over 5 per cent were followed by a readmission within five days.

Estimates of the absolute number and financial impact of readmissions within the entire Medicare population between 1974 and 1977 are shown in Table 3. These estimates are based on average per-beneficiary readmission rates within our 1 per cent sample and an estimated average cost per admission (in constant 1977 dollars) of $1,326.[3] Between 1974 and 1977 Medicare spent approximately $650 million per year (6 per cent of annual Medicare inpatient expenditures)[4] on readmissions that occurred within five days after a discharge and over $2.5 billion per year (24 per cent of Medicare inpatient expenditures)[4] on readmissions that occurred within 60 days after a discharge (Table 3). Given recent projections of 1984 Medicare admission rates and of average 1984 Medicare expenditures per hospitalization (Office of Financial and Actuarial Analysis, Health Care Financing Administration: personal communication), Medicare expenditures for readmissions in 1984 are likely to be over three times the estimates shown in Table 3.

To assess how many readmissions may actually have been interhospital transfers, we assumed that all readmissions that occurred within 24 hours of discharge and that involved an admission to a hospital other than that from which the patient had been discharged were in fact interhospital transfers. When we used this definition, our data suggested that 2.2 per cent of Medicare discharges between 1974 and 1977 were likely to have been interhospital transfers.

Patient and Hospital Characteristics

The relation between the probability of a readmission within 60 days of discharge and a number of characteristics of beneficiaries and hospitals is presented in Table 4. Medicare beneficiaries who were under 65 years old (i.e., those who qualified for Medicare benefits because they were disabled) had a slightly higher probability of being readmitted than did those who were over 65 (P<0.0001). Readmission rates did not vary with age among beneficiaries over 65. The probability of being readmitted was higher among men (P<0.0001 by Student's t-test), beneficiaries who lived in a rural area (P<0.0001), and those who were eligible for Medicaid (P<0.0001). The probability of readmission was lower in patients who underwent surgery (P<0.0001).

Examination of the characteristics of the hospitals from which patients were discharged suggests that the probability of readmission did not vary substantially with the region of the country but tended to be slightly higher in teaching hospitals than in nonteaching hospitals (P<0.0001) and in hospitals with fewer than 100 beds (P<0.0001).

Discussion

The increasing numbers and proportion of the elderly in our population are expected to have an important impact on future health-care costs in this country. In this paper, we have used a longitudinal data base to analyze the historical dimensions of one major contributor to the health-care costs of the elderly — readmissions to the hospital. Our analysis suggests several conclusions.

First of all, Medicare expenditures are highly concentrated on a small percentage of beneficiaries who are repeatedly admitted to the hospital. Over a four-year period, almost 60 per cent of Medicare inpatient expenditures were attributable to the 12 per cent of beneficiaries who were discharged three or more times. The observation that a large proportion of

Table 2. Interval between Discharge and Readmission among Medicare Beneficiaries Discharged between 1974 and 1977.

Interval	Percentage of Cases	Cumulative Percentage
no. of days		
<1	2.4	2.4
1-5	3.1	5.5
6-30	10.2	15.6
31-60	6.8	22.5
61-365	27.3	49.7

Table 3. Estimated Annual Number and Cost of Medicare Readmissions between 1974 and 1978.

Definition of Readmission	No. of Readmissions * (thousands)	Expenditures on Readmissions † (millions)
Admission within		
5 days of discharge	491	$651
30 days of discharge	1393	$1,847
60 days of discharge	2009	$2,563
365 days of discharge	4418	$5,385

*Average annual number of Medicare readmissions.

†Average annual Medicare expenditures on readmissions in constant 1977 dollars.

Medicare expenditures is attributable to a small percentage of beneficiaries who are repeatedly hospitalized is consistent with the findings of previous studies of high-cost users of medical care, which found that the expensive patients tended to be those who were hospitalized repeatedly, often for the same disease, rather than those with single, cost-intensive hospital stays.[1,2]

Secondly, we have found that a high percentage of Medicare hospitalizations are followed by readmissions within short periods of time. Over 5 per cent of hospitalizations in our study were followed by a readmission within five days of discharge, and over 22 per cent by a readmission within 60 days. Because patients who died during a hospitalization were counted as discharges in our analysis, these figures underestimated the actual probability of being readmitted within various intervals after discharge. Our analysis further suggests that interhospital transfers accounted for only a small percentage of these readmissions.

Although previous studies have not defined the probability of a hospitalized patient's being readmitted within various periods of time after discharge, earlier studies have developed data suggesting that readmissions occur frequently. In a study limited to men who were admitted to an acute-care hospital in Canada at least once in 1954, Roemer and Myers found that 27 per cent of the admissions were actually readmissions of patients who had already been admitted once before during the year.[5] More recently, in a study of geographic variations in hospital discharge and readmission rates of Medicare patients, Gornick developed data suggesting that approximately 28 per cent of Medicare admissions in 1972 were actually readmissions of patients admitted earlier in the year.[6]

Thirdly, we have found that the cost to Medicare of hospital readmissions is very high. Between 1974 and 1977, Medicare expended over $600 million per year on readmissions that occurred within five days of discharge and over $2.5 billion per year (24 per cent of Medicare inpatient expenditures) on readmissions that occurred within 60 days. These data, which quantify the cost of readmissions of Medicare beneficiaries that occur within various intervals after discharge, can be compared with the estimate by Zook et al., based on a study of patients ranging in age from under 20 to over 70 years, that repeated hospitalizations for the same disease account for nearly 60 per cent of all hospital charges.[7] Given inflation and projected 1984 Medicare readmission rates, our findings suggest that in 1984 Medicare will spend over $2 billion on readmissions that occur within five days of a discharge and almost $8 billion on those that occur within 60 days.

Medicare expenditures could be markedly reduced by small changes in the readmission rate, however. If the number of readmissions within 60 days could be reduced by 10 per cent (from 22 to 20 per cent), for example, Medicare expenditures could be reduced by 2.3 per cent, or more than $1 billion in 1984.[4] The recently enacted prospective-payment legislation, on the other hand, creates economic incentives that could increase the readmission rate. To the extent that physicians begin to discharge patients prematurely as a

Table 4. Relation between Characteristics of Patients and Hospitals and the Probability of Readmission within 60 Days.

	Probability of Readmission
Patient-related characteristic	
Age *	
<65	0.29
65–69	0.22
70–74	0.22
75–79	0.22
>80	0.21
Sex †	
Male	0.24
Female	0.21
City residence *	
Yes	0.21
No	0.25
Reason for Medicare eligibility †	
Disabled	0.29
Aged	0.22
Eligible for Medicaid †	
Yes	0.26
No	0.22
Surgery during admission *	
Yes	0.19
No	0.24
Hospital-related characteristic	
Region of country *	
Northeast	0.21
North central	0.22
South	0.24
West	0.23
No. of beds †	
<100	0.27
100–400	0.21
≥400	0.21
Teaching hospital †	
Yes	0.24
No	0.22

*P<0.05 by Student's t-test.

†P<0.0001 by Student's t-test.

result of the financial pressures implicit in the Medicare prospective-payment system or begin to "unbundle" multiproblem admissions into multiple admissions. Medicare expenditures for readmissions could well exceed our estimates. A recent analysis of the geographic variation in the incidence of hospitalization for numerous diagnosis-related groups has called attention to the fact that such "unbundling" could be accommodated within currently accepted variations in physicians' styles of practice.[8]

Readmissions may thus become a major concern to the Health Care Financing Administration. Professional review organizations, which will replace the more familiar professional standards review organizations, could assume responsibility for monitoring readmissions as part of their more general responsibility for monitoring hospital admission patterns. Our analysis suggests that any attempt by professional review organizations to develop hospital readmission profiles should control for a number of characteristics of patients and hospitals that appear to be correlated with the probability that a patient will be readmitted within a short interval after discharge. Medicare beneficiaries who are disabled, who are eligible for Medicaid, or who live in a rural area, for example, appear to be at increased risk for readmission. Patients who undergo surgery, in contrast, appear to have a decreased likelihood of being readmitted soon after discharge. Further study of these and other factors may not only provide more precise estimates of the probability of readmission for various types of patients but could also identify high-risk patient groups for whom increased outpatient supports might prove cost effective.

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Senator HEINZ. Mr. Goldwyn, I would like to ask you how we can improve upon our existing discharge planning practices, and more specifically, whether it would be helpful to have some tool to reflect a patient's dependent status?

Mr. GOLDWYN. We think so. We think that patients who are discharged in a more dependent state, do need better discharge planning and the discharge planners need a consistent assessment tool that gives them a reliable and a relatively convenient way to make that assessment and make it across the system. What we find in Oregon is that some hospitals have formal, organized, managed, computerized, discharge-planning systems where every patient that is admitted goes through the system, is evaluated, and comes with a recommendation on discharge.

There are hospitals where it is very informal and it is very random chance.

Senator HEINZ. A brief followup is this. S. 2331, Senator Durenberger's and my bill, requires that HCFA develop such a needs assessment tool within 1 year. Is there any reason HCFA can't do that?

Mr. GOLDWYN. I don't see why. I think it is essential.

Senator HEINZ. Thank you.

Senator DURENBERGER. Thank you very much.

Senator CHAFEE. Mr. Chairman, I just want to say that the information these witnesses have given us, I think, is really fascinating. For instance, one of the points you make, Dr. Anderson, is that the length of stay in the east coast hospitals is now equal to the pre-PPS length of stay in the west coast hospitals.

Dr. ANDERSON. Correct.

Senator CHAFEE. And then you point out that no one was suggesting that the length of stay in those west coast hospitals was inappropriate. Now, what has happened to the west coast? Have they dropped?

Dr. ANDERSON. They have dropped as well, and they have dropped substantially below where they were—approximately a 2-day length of stay shorter than where they were before PPS. So, it has been a uniform drop in length of stay across the United States.

Senator CHAFEE. Well, I certainly look forward to that Rand study and these other studies.

Senator DURENBERGER. Thank you very much. Our next panel is Donald Young, M.D., executive director of the Prospective Payment Assessment Commission; Eleanor Chelimsky, Director of the Program Evaluation and Methodology Division of GAO; and Judith Wagner, senior analyst of the Office of Technology Assessment.

Thank you all very much for your patience with us this morning. I agree with what John Chafee said about the value of this hearing and the value of the testimony of the various witnesses. Your statements will all be made a part of the record of this hearing, and we will begin with Dr. Donald Young from ProPAC. Don, thank you very much for being here.

STATEMENT OF DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WASHINGTON, DC

Dr. YOUNG. Thank you for asking us, Senator. The Prospective Payment Assessment Commission has always considered maintenance of high quality care our highest priority. Quality of care has guided our work in recommending an update factor and in our recommendations regarding adjustments to DRG classifications and waits to better account for patient severity.

One of the expected results of the changed incentives of PPS is indeed shorter lengths of stay, and this has been observed, as has been mentioned this morning, many times, resulting in a need for greater attention to posthospital services. ProPAC makes a distinction between earlier discharge and premature discharge. The former may enhance quality of care, if necessary posthospital care is available and is received. The latter, however, needs careful review, monitoring, and vigorous steps to eliminate it.

The role of hospitals as care-givers in the United States is changing, and greater reliance on posthospital care in the home, community, and other alternative settings is one result of this change. Therefore, earlier discharge puts new pressures on the health care delivery system outside of the hospital. Therefore, the problems related to earlier discharge may be related more to the absence of postdischarge care than to flaws in the Medicare prospective payment system.

Along with many others, the Commission became concerned about reports in the media and in testimony before congressional committees that quality of care was being compromised as a result of the implementation of PPS.

The Commission examined perceptions of quality of care in a study we funded last year. Several issues were raised in this review of the incidence of reported quality of care problems. These issues include, one, the discharge of beneficiaries more quickly because of shortened length of stay; two, a series of misconceptions about how the PPS system works and the nature of patients' rights; three, problems with availability or accessibility of alternative posthospital care; and four, deficiencies in the ability of PRO's to identify and monitor quality of care, especially the care immediately following the hospital discharge.

This study led to four recent Commission recommendations to the Secretary relating to the development of more and better information about PPS for both providers and for beneficiaries and limited expansion of PRO review beyond the hospital walls.

The Commission continues its research on the area of transitional or postacute care. And it has invited a panel of experts to discuss the methodologic approaches to improve the measurement of health outcome at its meetings later this month.

Finally, although the full Commission has not met since the introduction of S. 2331, and therefore has no formal position on the bill, the general thrust of the bill and many of its provisions are in keeping with the priorities and concerns of the Commission. We commend you and the sponsors of the bill for your interest and concern, and we would be pleased to assist the committee in any way possible and to answer any additional questions you may have.

Thank you, Mr. Chairman.

Senator **Durenberger**. All right. Don, thank you. Eleanor Chelimsky, I think you are next. Right?

Ms. **Chelimsky**. Yes.

Senator **Durenberger**. Thanks for being here. You have already been introduced by John Heinz.

[The prepared written statement of Dr. Young follows:]

TESTIMONY

Before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE

U.S. SENATE

June 3, 1986

For the

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Donald A. Young, M.D.
Executive Director
Prospective Payment Assessment Commission

Mr. Chairman, I am Donald A. Young, M.D., Executive Director of the Prospective Payment Assessment Commission. I am pleased to testify before you this morning to discuss ProPAC's views and observations about the quality of care received by Medicare beneficiaries under the prospective payment system. The Committee's interest in this subject serves to underline its importance and reflects a concern which we all share.

The Commission has always considered the maintenance of high-quality health care our highest priority. This priority has guided all of our reports and recommendations during the 2 years of our active participation in the policy development process surrounding PPS. In our first annual report to the Secretary of Health and Human services, containing recommendations for updating and maintaining PPS, we noted that "The Commission is keenly aware that the financial incentives of the prospective payment system may lead hospitals to lower their costs of providing services in a variety of ways, some of which may potentially compromise the quality of care provided to Medicare beneficiaries."

In fact, many of the results of incentives expected under PPS have been observed in the two years of the system's operation. Thus, in our February report to the Congress on Medicare and the American health care system, we noted several consequences of PPS with potential relationships to quality of care. Specifically, for example, the length of hospital stay has decreased, resulting in a need for greater attention to post-hospital services.

Therefore, we are especially concerned, as you are, about the quality of care related to Medicare patient's transition from the acute hospital setting to the community and home. Although patients may be discharged at an earlier point in their recovery, the implications of this change for health care outcomes are uncertain. For a variety of reasons, our society is changing its reliance on hospitals as care-givers. This has positive implications for quality of care, since a patient discharged sooner is not subject to the risks associated with hospitalization. Thus we think it is appropriate to make a distinction between earlier discharge and premature discharge. Earlier discharge may not only be acceptable but better for the patient, and may represent enhanced quality of care. Premature discharge, on the other hand, may represent a threat to high quality of care.

We believe that the decline in average length of stay increases demand for post-discharge services. In some areas, however, unavailability of these services limits access to needed services after discharge. The problems related to earlier discharge may, therefore, be more related to the absence of post-discharge services than to flaws in the Medicare PPS.

Commission Activities

The Commission strongly perceives its role as supporting the establishment of payment rates that will enable hospitals to continue to deliver high-quality health care. Thus, Commissioners have given implicit and explicit consideration to quality of care during debate and deliberations surrounding recommended changes needed to update payment amounts and appropriately modify the DRG classifications and weights. Adjustments to the DRG classification system are also important to encourage the use of more costly, but quality of care-enhancing new technologies and medical practices.

Last year, we also initiated a specific program of careful review, monitoring and research into a broader set of PPS quality issues. This work led to several recommendations in our April 1, 1986 report to the Secretary and expansion of our work in this area.

ProPAC Study of Perceptions of Quality of Care

Along with many others, the Commission became concerned about reports in the media and in testimony before Congressional committees that quality of care was being compromised as a result of the implementation of PPS. We decided that our initial work might best be focused on these reported incidents of poor quality care. Thus, through a research contract with Health Economics Research, Inc. (HER), we conducted a systemmatic review of incidents reported in the media and in testimony related to possible PPS quality of care problems.

We undertook this study for several reasons. First, it seemed appropriate to review reported incidents to ascertain if there was a pattern of problems or abuses related to quality. Secondly, even if the incidents reported were unrelated to quality, the perception of quality problems on the part of large numbers of beneficiaries and citizens seemed to us to call for thoughtful review of the situation and corrective action. Finally, we thought that a study of perceived quality of care problems would lead us to enhanced understanding of this area and assist us in further defining our future research and analytic agenda.

A few weeks into the study, HER encountered difficulties in identifying incidents of quality problems reported in the media. We then took steps to expand the scope of the study to include review of letters graciously made available to us by the American Association of Retired Persons. These letters were from beneficiaries who had experienced problems they felt related to quality of care under PPS. The study also included interviews with beneficiaries, providers, Peer Review Organizations, and leaders of associations representing these groups.

The results of the HER study are published in the Technical Appendixes to our recent report and recommendations to the Secretary, and are attached to my testimony. Briefly, the study identified several themes running through all of the reported incidents, which raised serious policy issues. These issues include: the discharge of beneficiaries more quickly because of shortened length of stay; a series of misconceptions about how the system works and the nature of patients' rights; the lack of availability or accessibility of alternative post-hospital care; and the inability of PROs to identify and monitor quality of care.

As noted in the conclusions of this study, the evidence reviewed illustrates the types of problems that Medicare beneficiaries have experienced under PPS. Perceptions are valuable in identifying problems with PPS, but the evidence presented is not sufficient to judge under what circumstances or to what extent quality of care has actually suffered under PPS. Clearly, earlier discharge, for example, does not necessarily equate with poor quality health care. Rather, as I noted before, it may be to the patient's advantage to receive care at home or in a community setting providing adequate alternative care is available and accessible. The problem, therefore, may be one of the structure and payment for post hospital benefits and the lack of services in some communities.

We believe that the information gathered in the HER study was significant, and it led us to develop four recommendations which were included in our second annual April 1 report to the Secretary.

Recent ProPAC Recommendations Related to Quality of Care
The four recommendations related to quality of care focus in two general areas: first, the need for more and better information about PPS and its functioning for beneficiaries, physicians, and hospitals; and, second, the need for expanded PRO review under PPS.

As I mentioned, our review of reported incidents found enormous misunderstanding about the most basic functioning of PPS. This misunderstanding is clearly not limited to beneficiaries -- in fact, it appears that beneficiaries often receive their misinformation from providers, who also do not understand how the system is designed to function. One of the most serious problems relates to the use of the DRG average length of stay as a definition of length of stay -- leading to the oft-quoted "Your DRG is up" misconception. This problem, coupled with a lack of information about beneficiary appeal rights, led the Commission to recommend that the Department develop (1) general information to describe PPS and the way it works and to make it widely available to providers, consumers and the public at large; and

(2) a specific notice written for beneficiaires who are hospitalized describing their rights of appeal in cases where they believe they are being improperly discharged. We are pleased that HCFA has recently written and required hospitals to distribute a notice of appeal rights. We understand that the agency is presently developing a general information pamplet or brochure as we also recommended. We believe that, well into the third year of PPS, these materials are long overdue. We hope that their availability will improve the understanding of the prospective payment system and result in fewer negative perceptions of the system and of the quality of care being delivered.

Two additional recommendations which were generated from our review of the study findings involve limited expansion of PRO review activities beyond the hospital walls. These recommendations call for PRO review of the entire episode of illness, including the quality of care (and outcome) related to skilled nursing or home health care. We noted in our discussion of this recommendation that changed financial incentives under PPS and changing patterns of care result in less frequent use of the hospital and more frequent use of skilled nursing facilities, other community facilities and the patient's home for treatment. Thus, the quality and level of care available to beneficiaries in these alternative settings directly influences the outcomes of the illnesses or problems for which beneficiaries were hospitalized, and they can directly affect the overall quality of care the beneficiary receives.

We also recommend that PROs should be required to review and monitor the quality of care and outcome of outpatient surgery for selected patients and procedures. Again, this is an area where changing practice patterns, encouraged by the PPS incentives and HCFA mandated PRO activities, have led to an increasing number of surgical procedures being performed on an outpatient, ambulatory basis. While ProPAC supports efforts to encourage performance of procedures in the most appropriate setting, it believes that the impact of this shift on the quality of care provided to Medicare beneficiaries needs to be further examined.

We hope that addressing these issues will alleviate some of the more critical short-term perceived and real quality of care problems. We also hope that implementation of these suggested procedures will lead to more sophisticated review of health outcome-related quality measures and focus attention on health system problems related to accessibility and availability of care after the hospital discharge. Our own plans are to focus some of our attention on quality studies which relate to the problems associated with the transition to post-hospital services and measurement of health outcomes under PPS.

Medicare Quality Assurance Act of 1986
As you know, Mr. Chairman, the Commission meets periodically and has not met since the introduction of S.2331. Thus, the Commission has not formally reviewed the many provisions of the bill. Certainly, the general thrust of the bill and many of its provisions are in keeping with the priorities and concerns of the Commission. We are pleased that the Committee is seriously reviewing quality of care problems, and we will be glad to continue to work with you as you refine your efforts in this area.

A major provision in the bill requires the Secretary to submit a legislative proposal by January 1, 1988 to improve the PPS classification and payment system to account for variations in severity of illness and case complexity which are not accounted for by the current classification and payment system. We are deeply involved in reviewing this subject. We are very supportive of efforts to better define the problems involved in case complexity and develop solutions for correcting these problems. We believe the timetable you have suggested is reasonable, though we would caution that while improvements will likely be possible by that time, a panacea should not be expected. Our own work in this area during the next year will involve major commitment to a systematic evaluation of the DRGs to assess the extent and underlying reasons for the heterogeneity which results from case complexity and to identify improvements in case mix measurement. In addition, we will be monitoring and examining research related to alternative case measurement systems. We will also continue to study individual DRGs and make recommendations for refinements which we believe are necessary to adequately reflect case complexity.

As I noted, we have recommended, as Title I of the bill requires, a notice to beneficiaries of their hospital discharge rights. I believe that the general idea of PRO review of denial determinations, as well as changes in the schedule for review and timing of beneficiary liability for payment, would be supported by Commissioners. Title I suggests the completion of a study of the adequacy of conditions of hospital participation in the Medicare program, which seems quite appropriate in light of the radically changed nature of reimbursement under PPS and significant other recent changes in health care delivery. The suggested study of payment for administratively necessary days likewise seems an appropriate area for careful review.

As I noted earlier, ProPAC shares the concern evident in the provisions of your bill which deal with access to appropriate post-hospital care. The Commission has not been involved in reviewing the specific areas of concern related to skilled nursing facilities and home health agencies covered in Title II of your bill, so I cannot comment in detail on these provisions.

The Commission likewise shares the concerns related to improved PRO review of quality of care. I have already described our formal recommendations in this area, which would result in activities which are similar to several of those contemplated under Title III.

Mr. Chairman, I appreciate this opportunity to appear before the Committee today to describe ProPAC's activities and concerns related to quality of care. In summary, we agree with the intent of S.2331 to better understand and improve the quality of care for Medicare patients as they move from the hospital setting to the community and home. I look forward to continuing to work with you on this important subject, and I will be pleased to answer any questions you or members of the Committee may have.

STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, PROGRAM EVALUATION AND METHODOLOGY DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. Chelimsky. Good afternoon, Mr. Chairman and members of the committee. I am really grateful to have the opportunity to be here. I think this is an extremely important hearing on the quality of health care, and it is a privilege to be asked to speak. You have my full statement.

Senator Durenberger. It will be made part of the record.

Ms. Chelimsky. And what I will do is simply summarize the highlights in the interest of the committee's time. What I wanted to say here this morning is based largely on recent GAO work in which we examined the availability of information about the effects Medicare's prospective payment system is having on posthospital care.

We looked for information on Medicare patients' condition at the time of discharge from hospitals, information on the quality of posthospital patient care, and information on patients 'access to that care. Our report was released today, as you know; it is that blue book that was passed around earlier. And as this committee already knows, we found that very little—pitifully little—information had been developed as of December 1985, more than 2 years—nearly 3 years—after the initiation of Medicare PPS.

This finding resulted in our undertaking more work, which is now ongoing in this area. First, a study of the experience of hospital discharge planners under Medicare PPS which would give us national data from 900 hospitals, targeted especially on the issue of access to posthospital care. Second, we are doing a study of health care quality measurement that will focus on short-term approaches using existing Medicare administrative data.

If we are successful, this study should allow the improved assessment of health care quality in the Medicare program nationally on at least some indicators. But our finding of little or no developed information also leads me to a more general point that I would like to bring to the attention of this committee.

Everyone knows, of course, that there is no such thing as a free lunch. If we want nuclear energy, we have to cope with hazardous waste. If we want severity in sentencing criminals, we have got to build more prisons or deal with overcrowding. If we want to cut health care costs, we have got to face the possibility of a decline in health service quality. But while we understand logically that what we do will always incur some costs, we understand it prospectively; what we never seem to anticipate is that, at one point or another, we are going to want to know how big that cost is and in fairly precise terms.

The problem is that, because we concentrate so completely on the benefits we hope to procure when the time comes to calculate the costs, it always seems to turn out that we haven't done the necessary planning to allow the measurements we need to make; definitions aren't agreed on; baseline data haven't been collected; no comparison base is available; and so on and so forth—the litany of what you have already heard this morning.

This is what is happening now with regard to health care quality. The Health Care Financing Administration has indeed reported on the expected program benefits, for example, reduced hospital expenditures, lower average lengths of stay under Medicare PPS; but we have heard little, if anything, about the expected costs of the program change, especially the problems that were widely predicted in posthospital care or general problems of quality such as those we are discussing today.

Evidence has been coming in over a few years now on individual cases of quality problems, not only in the area of premature discharge, but also inappropriate discharge—people not discharged prematurely from a medical viewpoint but inappropriately because their future care has not been assured. I think that the quantity of this evidence is sufficient to make it impossible to claim that no problems exist without first having done research expressly demonstrating that these cases with problems make up only a small proportion of the universe of cases nationwide, but no such research on the universe of cases has been conducted.

For example, Dr. Roper earlier spoke of the problems as "temporary." My question would be: How can he possibly know? Here we arrive at the nub of the problem. The time has come when we need to know what has happened to the quality of health care as a result of Medicare PPS, and we discover that we haven't done the planning necessary to be able to find out.

As my statement points out, the Peer Review Organization System was not designed to provide national data which are uniform and comparable across locales. The conceptual work needed in measuring quality under PPS is only now, as you have heard, in the early stages of development. There is considerable fragmentation in the administration of health care services, and what that means is that there is no single strong point of accountability for health care quality that includes all services to a patient. And finally, without that focus of accountability, it may be very difficult to muster the kind of drive, the concentrated effort, the resources needed to develop the information we have to obtain on health care quality.

In summary, Mr. Chairman, I think two points are critical here. First, efforts to provide for the measurement of quality should have begun before the initiation of Medicare PPS. Second, although there is undeniable evidence of problems in the quality of care provided to individual beneficiaries under PPS, we don't know the extent, the distribution, or the intensity of these problems, vis-a-vis the universe of problems nationwide.

Therefore, I conclude three things. First, that it is extremely important to take interim measures now to remedy cases in which patients have been prematurely or inappropriately discharged from hospitals or have received seriously deficient posthospital care. Second, I also think that caution is needed with regard to more extensive policy changes. We have to play catchup, and we need some time. In my opinion, such thoroughgoing shifts as altering incentives in the program or modifying coverage or eligibility criteria would best await strong information, not only on the magnitude and frequency of quality problems in the program nationally, but also on the reasons for those problems.

Finally, I believe it is critical for major programs like Medicare PPS that involve millions of Americans to build in the kind of research agenda before initiating the program that would make it possible to evaluate not only the predicted benefits of the program but also its costs. That concludes my statement, Mr. Chairman.

Senator **Durenberger**. Thank you very much. Dr. Wagner.

[The prepared written statement of Ms. Chelimsky follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m.
June 3, 1986

STATEMENT OF
ELEANOR CHELIMSKY
DIRECTOR, PROGRAM EVALUATION AND
METHODOLOGY DIVISION
ON

QUALITY OF CARE ISSUES IN THE MEDICARE PROGRAM

BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is a pleasure to be here today to share with this Committee some of the information we have developed on the quality of care provided by the Medicare program under the new prospective payment system (or PPS). In fiscal year 1985 Medicare spent approximately $37 billion under PPS for hospital care. More elderly Americans (over 27 million) are enrolled in Medicare than in any other federal program, including Social Security.

When the Social Security Act Amendments of 1983 were passed, the Congress recognized that incentives intended to cut costs could affect the quality of health care. Restraining costs by reducing services or lengths of stay could lead to greater efficiency, less inappropriate use of services, and better care for some patients. But if medically necessary and appropriate services were also curtailed, prospective payment incentives could have the unintended consequence of reducing the quality of care. A number of measures were taken at that time to minimize these potentially negative effects. The measures included the provision of supplementary payments for unusually complicated and costly "outlier" cases and the specific assignment of responsibility for oversight of quality of care to the Professional Review Organizations (or PROs). Our discussion today focuses on what we know about whether the quality review systems currently in place have effectively controlled the quality problems which could arise from the incentives built into the prospective payment system.

My comments will draw largely on the work we recently completed in which we examined the availability of information about the effects on post-hospital care of implementing the Medicare Prospective Payment System (PPS). In the course of doing this work, we came to the conclusion that some of the most important quality of care questions raised by the introduction of PPS can be addressed by focusing on two issues: the condition of Medicare patients when they are discharged from the hospital and the appropriateness of post-hospital placement for patients who require subacute care.

Today, I would like to focus on three concerns related to these points. The first has to do with the incentive structure, or the logic, of PPS. The second is the evidence about actual quality problems under PPS. The third involves reasons why more definitive information is not available.

Concerns About Quality of Care Posed by the Incentive Structure of PPS

Prior to PPS, when hospitals were reimbursed for individual services and days of hospital care, their financial interests could lead them to err on the side of providing too much health care. Even prior to PPS, there were problems in obtaining access to skilled nursing facilities for some patients. As a result, some of these patients remained in hospitals longer than medically necessary.[1] Further, the limitations of Medicare coverage for post-hospital services reinforced incentives to extend hospital stays past the point where patients' acute care needs had been met. Some extended care provided in hospitals could have been covered by Medicare in post-hospital settings. In other cases the extended care was probably custodial or supportive care for chronically ill patients; this would not qualify for Medicare coverage.

Extended hospital stays could have had negative quality consequences, given the danger of complications and infection that accompany all medical interventions. The prime objection to this system, however, was its cost. Medicare was seen as paying for too much unnecessary and inappropriate care.

Incentives to Provide Less Rather than More Care. In shifting to a system of prospective payment based on diagnosis, Medicare suddenly removed the financial incentive to provide more health care services than needed in hospital settings. Rather, hospitals now stand to gain the most by curtailing both services and days of hospital care whenever possible. Under this system, hospitals can profit financially from cutting back on medically appropriate, as well as inappropriate, services. Thus, the discharging of patients still in need of hospital care has become a primary quality concern under PPS.

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[1] GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. 110-15.

Predictions of Increasing Need for Post-Hospital Care. A second concern relates to the ability of hospitals to respond to PPS incentives to shift the provision of subacute care to appropriate post-hospital settings. Patients who no longer require acute care *should* be discharged from the hospital, but some of these patients are still not sufficiently recovered to care for themselves at home. Such patients are likely to experience quality of care problems if they do not receive appropriate and competent post-hospital care. This is likely to have occurred much less frequently since PPS came into effect and transformed extensions of hospital stays from generally profitable to relatively unprofitable activities. Given a new level of demand, it will probably take some time before providers of post-hospital care can expand to accommodate it. Until they do, some patients are likely to have trouble obtaining access to the post-hospital care they need. This problem is probably accentuated for patients requiring the most intensive forms of post-hospital services, such as respirator care. Because it has only recently become feasible to provide relatively complex care of this sort outside the hospital setting, post-hospital care providers may not have the equipment or enough trained staff needed to furnish it. Moreover, when providers of post-hospital care are found, the complexity of these procedures and greater vulnerability of patients dependent on them increases the likelihood of problems of quality.

Differential PPS Effects on Quality are Likely. The concerns about quality of care raised by PPS are likely to affect different groups of Medicare patients very unevenly. First, most Medicare patients have typically not used post-hospital care. For them, PPS incentives, at least in theory, pose fewer potential problems. However, the patients who do require post-hospital care tend to have had longer-than-average hospital stays. This could make them more likely to be targets of hospital cost-control efforts. Such patients are often frail or chronically ill, and have multiple health care problems. These conditions may render them less attractive for hospitals to admit, and harder to place in post-hospital care upon discharge.

Hospitals may respond by focusing more intensive discharge planning efforts on patients of this sort. To the extent that this will lead to appropriate post-hospital care, the results could be beneficial. Otherwise, the frail and chronically ill could experience disproportionate quality of care problems under PPS through a combination of premature discharges, inappropriate or substandard post-hospital care, or no care at all.

In addition, variations in hospital practice and health services resources across the country likely mean that there will be substantial differences in the way that PPS affects the quality of care. There are, for example, large variations in average lengths of stay in hospitals and in the availability of different types of post-hospital care. Hospitals which have relatively low lengths of stay or are located in areas with a relatively extensive networks of post-hospital care in place will probably have less difficulty adapting to the incentives of PPS without confronting major quality of care problems.

What Evidence Is There of Actual Problems in Quality of Care for Medicare Beneficiaries Under PPS?

Preliminary evidence from the U.S. Department of Health and Human Services indicates that hospitals have responded as they were expected to in terms of the incentives I have just described: average lengths of stay are down and the number of patients discharged to post-hospital care providers such as nursing homes and home health agencies appears to have increased sharply.[2] However, evidence of some quality of care problems stemming from these incentives has also emerged. There have been numerous reports of people having been discharged from the hospital in unstable medical condition, or without adequate provision for post-hospital care, or to inappropriate types of post-hospital care. We reported to the Senate Special Committee on Aging in February 1984 that there was substantial agreement among the hospital, nursing home, and home health care administrators and discharge planners and advocates for the elderly whom we met with in six communities across the nation that patients were being discharged sooner and in poorer states of health than before PPS. We were told that demand for post-hospital care had increased, and that patients in the post-PPS period required more intensive services after discharge from the hospital. At each site we visited, we were told of problems with obtaining appropriate subacute care for some patients, particularly those with extensive skilled nursing care needs.[3] Reports of similar problems have continued to surface since our preliminary report was issued.

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[2] Department of Health and Human Services, Report to Congress: The Impact of the Medicare Prospective Payment System, 1984 Annual Report, (Washington, D.C.: November 1985), p. 6-13, and 8-6 to 8-12.

Some work has begun on developing ways of measuring patients' level of dependency and their medical stability when they are discharged from the hospital. The early evidence seems to substantiate the common impression that patients are being discharged in less stable condition. However, we lack essential information on the extent to which patients are being discharged *prematurely*--that is, when they still require hospital care, or *inappropriately*--that is, when they no longer need acute care but have inadequate arrangements for post-hospital subacute care. We are currently examining some of the problems hospital discharge planners are experiencing in placing Medicare patients in post-hospital care. I expect the results of a national survey of more than 900 hospitals to be available this fall.

Premature Discharges. Physicians and hospital administrators testifying before both the House and Senate Aging Committees have reported that they have felt pressure to discharge patients earlier than is medically appropriate. However, the data on which to base any claims about the extent or severity of premature discharges under PPS are very limited. In October 1984, the Office of the Inspector General in HHS expressed concern about the possibility of a growing number of medically inappropriate discharges, transfers, and readmissions under PPS, but only limited reviews of a small number of cases were cited as evidence of this type of problem. While PROs have identified several thousand cases of premature discharge or incomplete care resulting in readmission within 7 days, the system of PRO review is not designed to produce uniform and comparable data. Therefore, PRO data cannot be used to estimate the incidence or extent of premature discharge experienced by the entire Medicare population.

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[3] *Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term Care Services: Preliminary Report,* GAO/PEMD-85-8 (Washington, D.C.: December 7, 1985).

Inappropriate Discharges. As with premature discharges, a great deal of testimony has been presented in House and Senate hearings describing instances of problems associated with patients' inability to obtain appropriate post-hospital subacute care. However, no systematic research has yet demonstrated the scope and magnitude of these problems.

PROs have no responsibility for reviewing post-hospital care services. Therefore, information on problems arising from lack of access to appropriate post-hospital care, or placement in inappropriate or substandard post-hospital care, cannot be obtained from PRO data. Most of the available information comes from providers and focuses on the increased demand for health care services perceived to be associated with earlier hospital discharges rather than on the direct assessment of the effect of earlier discharges on the quality of care. The available national, as well as regional and local studies show sizable increases in the provision of health-related services for elderly persons in the community after PPS and increased demand for extensive skilled nursing services and "high-tech" services, in both nursing homes and home care. Studies that demonstrate the effects of either premature or inappropriate discharges on the outcomes of patient care, however, have yet to be done.

Why Do We Not Know More About PPS Effects on Quality of Care Either in Hospitals or in Post-hospital Care?

PROs are the organizations charged with the responsibility of reviewing inpatient hospital care, and would seem to be the logical source of data on quality of care problems, including those associated with earlier discharges from the hospital. However PROs have not provided this information for a number of reasons.

Under their original scope of work, the specific types of discharge problems PROs reviewed were those that resulted in the subsequent readmission of a patient to the same hospital or readmission of a patient for care that could have been provided during the first admission.[4] Only readmissions to the same hospital within seven days were subject to mandatory review.

In addition, the case-by-case methodology PROs use to determine whether a premature discharge has occurred precludes the collection of uniform data on the incidence of such discharges nationwide. Each review rests ultimately on the individual professional judgment of the PRO personnel reviewing the case. The criteria guiding this judgment are developed by each PRO in accordance with local medical practice. Therefore, similar cases could be assessed differently by different PROs.

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[4] Health Care Financing Administration, "Peer Review Organization Manual," transmittal 5, Washington, D.C., August 1985, pp. 3-5.

Information on premature discharges has been limited also by the way in which PROs report their activities to the Health Care Financing Administration (HCFA). PRO review could lead to a variety of findings--inappropriate admission for the second hospitalization, readmission for legitimate reasons, or readmission needed because of inappropriate or poor quality care during the first hospitalization (which could include premature discharges). The reasons for readmissions were not routinely disaggregated in reports to HCFA. Consequently, summary statistics on readmissions and on payments approved or denied for readmissions would not provide information on premature discharges. Summary information provided to HCFA will be more extensive under the new round of PRO contracts, but data will not be available until these new contracts have been in effect long enough to conduct reviews, to record case findings, and to generate and analyze summary data tapes. Perhaps most significantly, PRO reviews do not provide information on cases of readmission resulting from premature discharge after the prescribed cut-off period (now 15 days) or on cases of premature discharge not resulting in readmission (including patients who were discharged and died without returning to the hospital).

PROs perform a valuable task in identifying and rectifying individual cases of poor quality care. The problems with PRO data that I have just discussed do not derive from poor performance on their part. The difficulty is that the PROs were not designed to provide aggregate information on the nation-wide incidence of premature discharges under PPS.

The limitations of PROs in generating information on the quality of care are not, however, merely a function of design. They reflect, among other things, three major barriers to the development of an effective quality assurance system for the Medicare program: (1) conceptual problems in measuring the quality of care, (2) fragmented administration of health care services for the elderly, and (3) the magnitude of research and development efforts required.

Conceptual Problems Make Measuring Quality Very Difficult. An important reason for the collective lack of information about the quality of care provided to Medicare beneficiaries is that people do not agree on what is meant by "quality of care." Quality can be viewed from the perspective of the practitioner, the patient, or the persons who are charged with overseeing the programs that serve the public, and these perspectives are sometimes divergent. What may be state-of-the-art clinical medicine from a technical and scientific point of view may be unacceptable to a patient whose expectations about appropriate treatment are not met or who is dissatisfied with the interpersonal or environmental aspects of the health care encounter. Assessing the quality of care provided to beneficiaries of a health care financing program requires the consideration of trade-offs between available resources and expected benefits, which may not be as important in assessing the quality of care rendered to an individual.

While there is no accepted standard definition of quality, there is some general agreement among experts that quality is a multidimensional construct, and that looking at different aspects of the structure, process and outcomes of care can produce meaningful and useful information. Clearly, the identification of deficiencies in physical plant and equipment (including technology) and the staffing, organization and professional training of persons working in health care facilities is essential to oversight, and so is the review of the activities performed in taking care of patients, including the gathering of information about diagnoses, procedures, therapy, follow-up visits, and so on. Under the pressures of cost-containment, however, a concern is growing about how these components of quality actually relate to the outcomes of care, as measured by changes in health status or patient satisfaction.

In attempts to make some overall judgments about quality, we have generally been limited to somewhat ambiguous proxy measures such as mortality rates and use rates, measures that are often difficult to interpret. For example, knowing that patients in a particular institution have a certain mortality rate is not useful in the absence of information on the complexity of cases treated in that institution and the expected mortality rates for similar groups of patients receiving appropriate care.

More comprehensive measures of quality would require linking variation in the process of care to differences in health outcomes or examining the quality of care provided in different settings throughout an episode of illness. Research in these areas is in the early stage of development.

The Fragmented Administration of Health Care Services Leads to Data and Accountability Problems. Assessing the quality of care is complicated further by the fragmentation of responsibility for quality oversight among different segments of the health care system. For example, Medicare covers acute and subacute care for the elderly; private payment and Medicaid cover most long-term care for the frail elderly and chronically ill and disabled. Therefore, federal programs have responsibility for the oversight of quality in different sites--hospitals and nursing homes, for example--and for different populations of beneficiaries--the acutely versus chronically ill. This fragmentation is exacerbated within the Medicare program itself, which covers a wide range of services under two separate insurance funds, and uses a variety of payment mechanisms--each with its own billing and administrative data--to reimburse providers of care.

As a result of divided responsibilities and diverse payment and administrative systems, the measures and mechanisms that have been developed for monitoring quality of care have tended to focus on different types of information and different aspects of quality. These various elements have not been tied together into a unified conceptualization of quality extending throughout an episode of illness. The immediate case in point is the system of PRO review, in which responsibility is limited by the parameters of the specific prospective payment system in place. PROs are responsible only for reviewing the quality of inpatient hospital care; they have no responsibility for monitoring other Medicare services or non-Medicare services received by beneficiaries.

Developing Stronger Information on Quality of Care Requires a Concerted Effort. To overcome barriers to the assessment of quality, significant efforts will be needed in both measuring quality and collecting relevant information. A first task is to clarify what is meant by "quality health care," particularly in the light of changing payment mechanisms and their associated incentives. Measurement development should be linked to improvements in the Medicare data collection system that would make it possible to apply comprehensive measures of quality throughout episodes of illness. At the same time, we need (1) to improve the system of PRO review so that it can generate valid and nationally representative information on quality problems, and (2) to devise ways to use this information to make systematic improvements in quality of care.

We have begun a study that will take some initial steps towards these ends. Our work will focus on relatively short-term approaches for assessing the quality of care that can use Medicare administrative data. Given the scope and complexity of the issues involved, however, a major research and evaluation effort will be required from HHS and others if the full range of quality of care issues is to be adequately addressed.

It should be noted that the development and refinement of many existing quality assurance methods was accomplished, in part, by the availability of federal research funds throughout the 1970s. As policy concerns for health care costs increased, these concerns were reflected in shifts in priorities and agendas for funding research, and this resulted in decreased emphasis on quality-related studies. The present congressional hearing and the increased attention devoted to problems of health care quality suggest a need to reassess priorities for health services research. Greater attention to developing appropriate quality measures is essential. Studies to delineate the magnitude and types of health care quality problems occurring in the Medicare program and to develop systematic approaches for improving quality depend upon such basic developmental efforts.

Conclusions

To summarize, we have three major concerns about assessing the quality of care in the Medicare program under PPS:

First, the incentives created by prospective payment are such that providers could profit by cutting back on medically necessary care. However, these incentives operate more or less strongly for different types of patients and providers. Analyses based on individual cases or local or regional studies could be misleading. Therefore, it is critically important to develop information on quality of care that is national in scope and represents the population as a whole.

Second, virtually every source we have reviewed reports some problems of quality under PPS that are consistent with the logic of these incentives. The numerous descriptions of individual cases which have emerged since PPS came into effect are also consistent with this logic. Further, as I previously testified before the Senate Special Committee on Aging, our work has uncovered no systematic research demonstrating that such quality of care problems are not significant. Based on the available evidence, we believe that there are some instances of serious problems with the quality of care provided to Medicare beneficiaries under PPS. However we do not know the extent, distribution, or intensity of these problems.

Third, significant barriers to obtaining better information derive from a combination of measurement problems, fragmented administrative responsibilities, and decreased emphasis on essential research and development. These barriers will not be overcome unless a systematic and extensive effort--and the resources to support this effort--are directed to the task.

The current gaps in information should not, however, preclude consideration of the genuine instances of problems of quality that have arisen under PPS. Although we cannot yet determine the distribution and intensity of these problems, some interim measures to remedy cases of premature discharge and seriously deficient post-hospital care as they occur are clearly justified. There should be effective mechanisms to provide patients with full and accurate information about their rights; procedures to deal immediately with Medicare patients' urgent problems related to hospital discharge decisions and placement in post-hospital care are also needed. Without better information on the nature of the quality of care problems occurring in the Medicare program, however, the basis is lacking for considering more extensive policy changes intended to adjust the basic incentive structure of PPS, or substantively change Medicare eligibility criteria or its coverage of subacute health care services.

This concludes my prepared statement. I will be happy to answer any questions you or any other members of the Committee have.

STATEMENT OF JUDITH L. WAGNER, PH.D., SENIOR ANALYST, OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, WASHINGTON, DC

Dr. WAGNER. Thank you, Mr. Chairman, I am Judith Wagner, Senior Analyst in the Health Program of the Office of Technology Assessment. I am pleased to appear before you to discuss the impact on quality of care of Medicare's prospective payment system.

Today, I would like to address two questions: First, what do we know about the impact of PPS on the quality of care delivered to Medicare beneficiaries? And second, what options are available to the Congress to address the most critical threats to quality arising from PPS?

Two and one-half years after the transition to PPS began, there is still today little hard evidence on the impact of the program on the quality of care delivered to Medicare beneficiaries. This is certainly a statement you have heard earlier today. We do know that the patterns of care to Medicare patients have changed markedly. Reductions in the length of stay and admissions suggest that Medicare patients who are hospitalized are on average likely to be sicker and are leaving the hospital earlier than they would have before PPS was enacted. What these changes mean for quality of care, however, cannot be assessed with the data currently available.

Did those patients who were discharged earlier have better outcomes or worse outcomes? Studies have simply not been mounted to answer this question with any confidence.

Anecdotal evidence of patients encountering problems in obtaining adequate posthospital care in the home or in nursing homes has increased our sensitivity to the possibility that the gains in hospitals' efficiency have come at the cost of quality, at least for some people. Anecdotes have serious shortcomings as a valid source of information. They are likely to be biased toward the negative and focus on unusual cases, but they can be most useful as early warning signals of potential problems.

Reliance on these sources alone, without further analysis, however, exposes policymaking to the risk of serious errors. At present, there is no other source of information on the quality impacts of early discharge. Yet, even without hard evidence, it is prudent at this time to focus on the most critical threats to quality raised by PPS and to search for ways to deal with them. Three potential threats to quality under PPS are the threat of underprovision of services to patients in the hospital, the threat of too-early discharge of hospitalized patients with inadequate posthospital care, and the threat of inadequate access to hospital care for unprofitable populations.

Under the DRG payment system, very old people and alcoholic or mentally ill people in need of hospitalization for medical problems are particularly vulnerable. In my opinion, the most important requirement in the long-run maintenance of quality of care for Medicare beneficiaries is that hospitals receive adequate revenues.

In a hospital industry in which 85 percent or more of hospitals are not for profit, the institutional ability to maintain and even enhance quality will be compromised most severely if the resources to provide high quality care are withheld. In drafting the PPS law, Congress created ProPAC and required it to analyze and recommend an appropriate annual increase in the average rate of payment. While ProPAC has carried out this task with skill and sensitivity, the budget situation continually puts pressure on the administration and Congress to reduce the rates of increase and even to freeze rates. Hospitals may be able to absorb these resource limitations without compromising quality in the short run.

Eventually, however, the fat in the system will be removed, and further cuts may come at the expense of quality. Congress could further enhance the capability of the hospital payment system to maintain quality at little additional cost by strengthening patients' access to the information necessary to protect themselves against premature discharge or unnecessary transfer and by enjoining physicians from teaming up with hospitals for mutual financial gain.

It also makes sense to require the Department of Health and Human Services to continue to submit annual impact reports beyond the current 1987 sunset date. Other approaches are likely to be more costly and of more uncertain impact.

That concludes my prepared remarks. Thank you.

Senator DURENBERGER. Thank you, all of you.

[The prepared written statement of Dr. Wagner follows:]

STATEMENT OF

JUDITH WAGNER, SENIOR ANALYST

OFFICE OF TECHNOLOGY ASSESSMENT

BEFORE THE

SENATE COMMITTEE ON FINANCE

ON

THE IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE

JUNE 3, 1986

Thank you, Mr. Chairman and members of the Committee. I am Judith Wagner, Senior Analyst in the Health Program of the Office of Technology Assessment. I am pleased to appear before you to discuss the impact on quality of care of Medicare's prospective payment system (PPS).

Early in 1984, your Committee and the Senate Special Committee on Aging asked OTA to conduct an assessment that would identify potential economic and health-related effects of PPS and develop a series of strategies for an evaluation of the most important effects. The assessment was initiated in May 1984, and our report, Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality, and Medical Technology was approved by OTA's Congressional board in June 1985. The report was published and delivered to your Committee in October 1985.

In the report, OTA arrayed the possible effects of PPS on the health care system--including those on the quality of care--and assessed the extent to which these effects can be measured. The report also identified critical PPS evaluation questions. In addition to identifying studies that would address the critical evaluation questions, OTA attempted to put the studies in a priority order, based on their cost and feasibility. Since publication of the report, OTA has informally continued to monitor the status of the evidence on the effects of PPS on the health care system. My testimony is based both on the findings of the OTA assessment and on information obtained in the ensuing six months.

Today, I would like to address two questions: First, what do we know about the effect of PPS on the quality of care delivered to Medicare beneficiaries? And second, what options are available to the Congress to address the most critical threats to quality arising from PPS?

When Congress mandated the transition from cost-based hospital reimbursement to PPS for Medicare, it radically altered financial incentives for the amount and mix of inpatient services provided to the elderly. At the time, the nation had little experience with such prospective payment systems. Though several States had introduced prospective hospital rate setting programs before PPS, they were all substantially different in design from the national program and in any event, none had been adequately evaluated for impacts on quality of care. Congressional awareness of potential problems with PPS was evident from the beginning; the Secretary of Health and Human Services (DHHS) is required by the PPS law to prepare annual reports through 1987 on how PPS is affecting providers and Medicare beneficiaries.

Today, two and one-half years after the transition to PPS began, there is still little hard evidence on the impacts of the program on the quality of care delivered to Medicare beneficiaries. We do know that the patterns of care to Medicare patients have changed markedly. For example, the average length of hospital stays for Medicare beneficiaries declined sharply during fiscal year 1984, but appears to have leveled off in fiscal year 1985. Medicare hospital admissions declined in both fiscal years. Taken together, these trends suggest that Medicare patients who are hospitalized are on average likely to be sicker than those who were hospitalized before PPS and patients, on the average, leave the hospital earlier than they would have before PPS was enacted.

What these changes mean for quality of care, however, cannot be assessed with the data currently available. Did those patients who were discharged earlier have better or worse outcomes? Studies have simply not been mounted to answer this question with any confidence. Anecdotal evidence of patients encountering problems in obtaining adequate post-hospital care in the home or in nursing homes has increased our sensitivity to the possibility that the gains in hospital efficiency have come at the cost of quality, at least for some people. Anecdotes have serious shortcomings as a valid source of information--they are likely to be biased toward the negative and focus on unusual cases--but they can be most useful as early warning signals of potential problems. Reliance on these sources alone, without further analysis, however, exposes policymaking to the risk of serious errors. At present, there is no other source of information on the quality impacts of earlier discharge.

Why do we know so little about the impacts of PPS on the quality of care delivered to Medicare patients? Several factors contribute, but two are especially important. First, methods for measuring quality of care is not well developed and data are not readily available even for existing measures. The benefits patients get from receiving medical care include improvements in the quality of life as well as extensions of the length of life. Quality of life includes not only objective measures of illness and functional status but also more subjective measures of emotional well-being and satisfaction. Tracking changes in these measures is difficult and costly and inevitably requires the selection of incomplete and imperfect proxy measures.

Second, the effects of PPS on the quality of care are likely to emerge gradually, and the more serious effects may not appear for a number of years. Initially, PPS impacts on quality may be small because of the gradual transition from cost-based reimbursement to PPS and the ability of hospitals to achieve savings through management and clinical efficiencies that have little effect on outcomes. As slack in the system is taken up, however, PPS could force economies that are inconsistent with maintaining quality of care. In short, although some PPS effects on quality of care may surface relatively early, others that ultimately are more important may take some years to be detected and documented. A mature assessment of PPS will be possible only after a substantial period of time has elapsed, perhaps as many as five years.

It is important to note that PPS can change the quality of care in positive as well as negative directions. For example, more skillful hospital management may lead to desirable clinical efficiencies, such as improved choices of diagnostic or therapeutic interventions. And, earlier discharge exposes patients to fewer risks of hospital-induced illnesses. Nevertheless, even without hard evidence, it is prudent at this time to focus on the most critical threats to quality raised by PPS and to search for ways to deal with them.

Two potential threats to the quality of care received by Medicare beneficiaries are inherent in any prospective per-case payment system and are not unique to the diagnosis-related group or DRG-based system used by Medicare. They are:

1) the threat of underprovision of services to patients in the hospital; and
2) the threat of too-early discharge of hospitalized patients, with inadequate post-hospital care.

The incentives for hospitals under per-case payment are not only to treat patients in as inexpensive a way as possible, but to admit profitable rather than unprofitable ones. Which patients are likely to be profitable is determined by the specific system used to classify patients. The DRGs themselves create a specific pattern of winners and losers in this regard; other patient classification systems would produce a different pattern. To the extent that hospitals can tailor their patient mix to minimize unprofitable admissions a third threat to quality is raised: the threat of inadequate access to hospital care for the unprofitable populations. Under the DRG-based payment system, very old people and alcoholic or mentally ill people in need of hospitalization for medical problems are particularly vulnerable.

The extent to which any of these threats to quality will actually manifest themselves depends on five factors: 1) the amount of "fat," or unnecessary medical care and inefficiency, that existed at the start of PPS and which could be pared down with little impact on health outcomes; 2) the rate at which DRG prices are permitted to increase from year to year to keep pace with inflation; 3) the degree of cost containment pressure on nonhospital services, such as home health or skilled nursing facilities, that are partial substitutes for hospital care; 4) the degree to which physicians act as advocates for their patients rather than as advocates for the hospital's financial status; and 5) the effectiveness of the Utilzation and Quality Control Peer Review Organizations (PROs) in monitoring and assuring quality of care.

In my opinion, the most important requirement for the long-run maintenance of quality of care for Medicare beneficiaries is that hospitals receive adequate revenues. In a hospital industry in which over 85% of hospitals are not-for-profit, the institutional ability to maintain and enhance quality will be compromised most severely if the resources to provide high-quality care are withheld. In drafting the PPS law, Congress created the Prospective Payment Assessment Commission (ProPAC) and required it to carefully analyze and recommend to DHHS an appropriate annual increase in the average rate of payment. While ProPAC has carried out this task with skill and sensitivity, the budget situation continually puts pressure on the the Administration and the Congress to reduce the rates of increase and even to freeze rates. Hospitals may be able to absorb these resource limitations without compromising quality in the short-run; eventually, however, the fat in the system will be removed, and further cuts may come at the expense of quality.

Congress could further enhance the capability of the hospital payment system to maintain quality with little additional funding by strengthening patients' access to the information necessary to protect themselves against premature discharge or unnecessary transfer and by enjoining physicians from teaming up with hospitals for mutual financial gain. It also makes sense to require DHHS to continue to submit annual PPS Impact reports beyond 1987.

Other approaches are likely to be both more costly and of more uncertain impact. Whether PROs can perform quality assurance in an effective fashion is unclear. Recent PRO contracts have stressed quality, but it has not been demonstrated that they will result in adequate protection against the threats to quality. At the heart of the problem is a shortage of adequate nursing home and home care services. To assure continued quality of care, access to the post-hospital care system for Medicare beneficiaries will need to be improved, a solution that can be achieved only at considerable cost.

This concludes my prepared remarks. I will be happy to answer any questions you might have. Thank you.

Senator **DURENBERGER**. I will ask just one quick question of you, Eleanor. One of the conclusions in the GAO study, as I understand it—I haven't had a chance to look at it—is that PPS provides incentives for hospitals to cut back on medically necessary care. I am not sure that is true, and I don't want you to try to demonstrate it for me here today.

Ms. **CHELIMSKY**. I don't think we said it exactly that way; I hope we didn't.

Senator **DURENBERGER**. All right.

Ms. **CHELIMSKY**. It seems to me what we were saying was that there are incentives that would make it possible to profit by letting people out sooner, but that doesn't mean that there are incentives for them to do that.

Senator **DURENBERGER**. All right. Now, is there evidence to what degree they are doing it? I noticed in reading some of these statements that hospitals are either bringing people in at a higher DRG than they ought to be at in order to make some money, or at least there is the implication that they might be sending them out early to bring them back.

Ms. **CHELIMSKY**. I think you have heard several times this morning—and we agree absolutely with what has been said—that what we have is individual instances of people who may or may not have been—you know, you would have to go and follow it up yourself, but we would give them the benefit of the doubt—it seems to me quite clear that the evidence is there of these individual cases. What we are lacking is some sense of—and we would need this information to be able to answer that question—what is happening on a national basis. Is that in fact occurring? Is it a jack or a deuce, in other words? Are we talking about an ocoasional thing? Is it temporary? Is there a big difference? And is it due to PPS? We don't know any of that.

Senator **DURENBERGER**. All right.

Ms. **CHELIMSKY**. What we do know is that people are having problems. We do know that.

Senator **DURENBERGER**. All right. John Chafee.

Senator **CHAFEE**. Thank you, Mr. Chairman. I must say, Dr. Young, this is an extraordinary statement, which I am not sure the American Hospital Association would agree with; that is, one of the positive implications for quality of health care—this has a positive implication for quality of care, that is, getting out of the hospital soon.

Since a patient discharged sooner is not subject to the risks associated with hospitalization—in other words, don't go into that place; it is a dangerous place to be. Is that it?

Dr. **YOUNG**. Yes; I don't think they would disagree with that. I think, as a physician, hospitals are not good places to be. Bad things happen to people. I know they have good things happen to people as well, but so do bad things.

Senator **CHAFEE**. But get out as soon as you can with your health?

Dr. **YOUNG**. Yes.

Senator **CHAFEE**. What this panel has brought home to me is the difference between what you term "premature discharge" and "inappropriate discharge," and in some cases, an "earlier discharge."

Do you all agree—here is my question—that whereas we don't know the data today on the effects of PPS, nonetheless it does seem clear that the problems related to earlier discharge are more related to the absence of postdischarge services than to flaws in the Medicare PPS?

In other words, we don't know the effect of the PPS, but we do know there must be better postdischarge services and facilities. You say it, so you must agree with it.

Dr. YOUNG. Yes, sir.

Ms. CHELIMSKY. I wouldn't agree with it. I would agree that we do need more services in some areas and regions; that is quite clear. And we certainly need more appropriate discharges. In other words, I would agree that we should have discharge planners in every hospital because I think that has to be done; but I think the fact that we don't know the universe and that we don't know the effects of PPS would keep us from being able to target services properly.

Senator CHAFEE. No, but my question is this. Everybody who has testified has said we don't know what the data are. We don't know what it is going to conclude.

Ms. CHELIMSKY. Right.

Senator CHAFEE. Each of you has said that. Nonetheless, doesn't it seem appropriate to proceed to encourage those postdischarge services or facilities now? Yes or no?

Ms. CHELIMSKY. I am uncomfortable with it because I don't know what the data show. I would want to know what the problem is. I would want to know the extent of it before I would want to advocate some large changes.

Senator CHAFEE. All right. What would you say, Dr. Young? What do you think we ought to do? If discharge services are lacking, what are they?

Dr. YOUNG. Postdischarge services go all the way from acute skilled nursing level of care for some patients to the care they receive in the home from the family and a loved one.

Patients who are in the hospital are generally sick. That is the reason they are in the hospital. And our society has put an immense amount of focus on the hospital as an important institution and on the doctor's office. Until recent years, we denied the existence of anything in between, and yet the natural history of an illness is not a herky-jerky I am sick enough to be in the hospital now, and an hour later I am well enough to be at home. It is a continuum.

If the individual needs rehabilitation, that can be given by a spouse, a family member, a loved one.

Senator CHAFEE. Do you think we ought to be doing something now, while we are waiting for the data to come in? Do you think we ought to be doing something to encourage those postdischarge services?

Dr. YOUNG. First, I absolutely agree we need the data. We need to know and understand better what is happening and to have some judgment as to how it relates to PPS incentives. In many respects, it may not. What is happening now may be no different than what was happening 5 years ago. We don't know. Second, I think we need to engage in and begin discussing in a dialog the current structure of the Medicare Program and its benefits so that we can begin to make the changes in the future.

The structure of it currently is simply not in keeping and in pace with the way the services are organized, delivered, and financed today. And now is the time to begin that kind of discussion and put in the research necessary and use the data that we are gathering to help us formulate the future.

Senator CHAFEE. Well, that is a big order. What do you say, Dr. Wagner?

Dr. WAGNER. With respect to the issue of the availability of posthospital services, it is not clear to me how much—at least in some areas of the country—how much of the problem is due to the lack of facilities and services per se as it may be a problem of management of the patient's access to those services.

Senator CHAFEE. My time is up. What would you do if you were sitting here about this problem? Would you sit around and wait until we get the data, or do something?

Dr. WAGNER. I think there are some elements of the Senate bill, Senators Durenberger and Heinz' bill, that will begin to address some of these potential threats. I think there are some very good elements in that bill, and that is a good starting point.

Senator CHAFEE. Do you agree with that, Ms. Chelimsky?

Ms. CHELIMSKY. Yes. I think it is a very good starting point, but I would worry, as I said, about taking large steps without data.

Dr. YOUNG. I agree it is a good starting point, but only a starting point.

Senator CHAFEE. All right, fine. Thank you very much.

Senator DURENBERGER. John, thank you very much; and thank you, panelists. We appreciate your being here.

Next, we have a panel of Dr. Harrison L. Rogers, president of the American Medical Association; Andrew Webber, the executive vice president of the American Medical Peer Review Association; Dr. William Moncrief, president of the California Medical Review, Inc.; and Louise Crooks, president-elect of the American Association of Retired Persons.

Ladies and gentlemen, your testimony has been received in advance as required, and it will be made part of the record. You may now proceed to summarize your testimony, beginning with Dr. Rogers.

STATEMENT OF HARRISON L. ROGERS, JR., M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ATLANTA, GA

Dr. ROGERS. Thank you, Mr. Chairman. My name is Harrison Rogers, and I am president of the American Medical Association. Accompanying me today is Mr. Bruce Blehart of the AMA's Department of Federal Legislation.

Mr. Chairman, the AMA is deeply concerned about the impact of the changes in the Medicare Program on the ability of physicians and hospitals to assure their continued availability of high-quality health care services for the Medicare population. The combination of the incentives for reduction in care that are inherent in the PPS and the fact that hospital reimbursement under this system routinely has been scaled back even prior to full implementation of the system point to increasing pressures to turn Medicare beneficiaries out of hospital at a quicker rate with all of the problem attendant to early hospital discharge.

This has been documented through our DRG monitoring project. The association initiated this project 2 years ago to determine how PPS may affect the quality of patient care. As of May 15, 1986, 443 written responses representing approximately 8,050 physicians have been received. Of the comments received concerning quality of care, 66 percent stated that quality had deteriorated. Concerns have related to early discharges, limitation on laboratory tests of hospital stays in which a second patient condition or complication requires treatment. Of the comments received concerning the cost of care, 85 percent reported that reimbursements at their hospitals were inadequate for one or more DRG's.

Areas of concern continue to be that severity of illness is not appropriately accounted for in DRG's, and small or rural hospitals are continuing to experience losses on DRG's. Of the comments received concerning discharge policies, 43 percent reported that there was pressure to discharge patients early, and 32 percent reported that policies have changed for the better.

In a separate survey of physicians recently conducted by the AMA, 40 percent of those physicians surveyed reported that they have discharged Medicare patients from hospitals earlier than they had before the implementation of DRG's. Of this 40 percent who stated that they have discharged patients earlier under the DRG system, 39 percent of those physicians reported that the earlier discharges have worsened the health status of their patients.

In addition to the collection of this type of survey data, the AMA is currently working with Johns Hopkins University to develop a series of research proposals that could result in a multifaceted study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries.

S. 2331, introduced by Senator Heinz, contains a number of provisions that are intended to address many of the quality of care problems created by the PPS. The AMA supports the goals of S. 2331 and many of the bill's provisions.

Specifically, we strongly support requiring the Secretary of HHS to develop a legislative proposal that would refine the PPS to better account for severity of illness and case complexity, studying the needs for a separate payment to hospitals for continued inpatient stays necessitated by delays in beneficiary placement in appropriate extended care facilities, and requiring hospitals to establish a discharge planning process that meets appropriate guidelines and standards.

In conclusion, the AMA is concerned about the potential for the deterioration in the quality of health care available in this country. Our concerns are heightened by the fact that Medicare has repeatedly been targeted for cuts, freezes, and major program modifications in the budget process.

Mr. Chairman, in the interest of the elderly patients of this country, I am compelled to place squarely before the committee a growing concern among our physicians who treat Medicare patients. While physicians have been trained to be advocates for and protectors of their patients' health, physicians are increasingly being pushed into the uncomfortable position of being the advocate for and the protector of the Federal budget. Physicians who err on the side of patient advocacy are at minimum subject to challenge and at worst they are subject to severe sanctions. Physicians generally have resisted the mounting pressures to discharge patients prematurely. However, we are deeply concerned over the application of such pressure, particularly in cases where the need for continued hospitalization is not clear cut.

In such cases, we believe that physicians should err on the side of the patient, without fear of recrimination or penalty. We hope there will be a return to support back for strengthening the physician advocacy role for the patient and for removing the compromising climate and adversarial relationship that today surrounds this relationship.

Thank you.

Senator **Durenberger**. Thank you, Dr. Rogers. Andy Webber.

[The prepared written statement of Dr. Rogers follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

RE: Quality of Care Under Medicare's
Prospective Pricing System

June 3, 1986

Mr. Chairman and Members of the Committee:

My name is Harrison L. Rogers, M.D., and I am President of the American Medical Association. We are pleased to have this opportunity to share our concerns over the increasing reality of Medicare beneficiaries leaving our nation's hospitals while still in need of acute care. We will also express our views concerning S. 2331, the "Medicare Quality Protection Act of 1986."

Mr. Chairman, the creation of the Medicare program represented a commitment to the elderly that this nation would assure them access to, and meet the major part of the cost of, high quality health services. To a large extent that promise has been met. The years since the enactment of Medicare have seen tremendous improvement in not only access to high quality health care but also in the health status of the covered population. One of the major reasons for this result has been the ability of the elderly to receive care in the same mainstream fashion as other individuals. We want these gains to continue.

The American Medical Association is deeply concerned about the impact of changes in the Medicare program on the ability of physicians and hospitals to assure the continued availability of high quality health care services for the Medicare population. We are concerned in particular that the prospective pricing system (PPS) may be a step back from the gains of the past twenty years. The combination of the incentives for skimping on care that are inherent in the PPS and the fact that hospital reimbursement under this system routinely has been scaled back even prior to full implementation of the system points to increasing pressures to turn Medicare beneficiaries out of hospitals at a quicker rate with all of the problems attendant to premature hospital discharge.

Since 1980, the Medicare program has been subjected to a continuing series of cuts and modifications that have caused considerable stress and anxiety over the ability of the program to meet the needs of its covered population. Each budget brings a new series of proposals to reduce Medicare expenditures, and this has been compounded even further by the addition of the Gramm-Rudman-Hollings reductions that are currently cutting back on Medicare reimbursements. There is an atmosphere of constant change and lack of stability in the Medicare program that is a serious threat for the 30 million program beneficiaries.

The AMA's DRG Monitoring Project

The American Medical Association initiated its DRG Monitoring Project in June 1984 to determine how PPS may affect the quality of patient care. As of May 15, 1986, 443 written responses representing approximately 8050 physicians have been received. Comments were provided by physicians in almost every state, representing over 20 different medical specialties, teaching and nonteaching institutions, and urban and rural areas. A majority of the responses were received from chiefs of medical staffs who incorporated the comments of their entire medical staffs. Several chiefs of staffs conducted their own surveys and forwarded the results to the DRG Monitoring Project. (The December 1985 Report on the DRG Monitoring Project and the Prospective Pricing System is attached to this statement as Appendix A.) These responses can be summarized as follows:

- Of the comments received concerning quality of care, 66% stated that the quality had deteriorated. Concerns have related to early discharges, limitations on laboratory tests and hospital stays in which a second patient condition or complication requires treatment.
- Of the comments received concerning the cost of care, 85% reported that reimbursement in their hospitals was inadequate for one or more DRGs. Areas of concern continue to be that severity of illness is not appropriately accounted for in DRGs, small or rural hospitals are continuing to experience losses on DRGs, and reimbursement is inadequate for some DRGs.
- Of the comments received regarding length of stay (LOS), 65% stated that LOS had decreased under PPS. An additional 25% questioned the appropriateness of LOS for certain DRGs.
- Of the comments received concerning discharge policies, 43% reported that there was pressure to discharge patients early, and 32% reported that policies had changed for the better.
- Of the comments received addressing administrative relations, 42% reported a deterioration in administration/physician relations, and 28% reported an improvement in such relations.

Mr. Chairman, the Monitoring Project helps to focus attention to the potential problem areas in the PPS. However, statistics pale in comparison with the actual statements we have received from physicians on how the PPS is affecting the care of their patients. The following are excerpts from submissions to the DRG Monitoring Project:

- "Our hospital has a good outpatient nursing care service, and we seem to have gotten by with sending patients home earlier without too much trouble, except for one of my recent patients. This was a 75-year old lady with chronic lymphatic leukemia, diabetes, and hypertension which is difficult to control, who unfortunately developed severe herpes zoster of the face and tongue and was unable to eat. We were pushed into sending her home. Despite visiting nurses, she did not eat and drink enough liquids and became dehydrated, and had to be re-admitted three days later. It would have been better for the patient had we just kept her in the hospital."

- "[The PPS] has affected relations among administrators and physicians, since physicians are being told they cannot maintain patients in the hospital at a stay longer than what the hospital is able to afford even if the patient should still be in the hospital, but the hospital cannot afford this. It is creating stress between administrators and physicians and between physicians and utilization review physicians."

- "There is no question that during the medical staff meetings, the administration is no longer concerned about the welfare of the patient. The only concern that we ever discuss in staff meetings, much to my objection, is the economics of the patients."

- "This program is having definitely negative impact on health care delivery. We have hospital administration telling us to treat one medical problem at a time: clearly contrary to our training to treat the total health problems of the patient in the most efficient manner. We are under unsubtle pressure to cut days and utilization of services: clearly a compromise of our right to exercise our best medical judgment.

  Already I am experiencing the distressing problem of pushing a patient out just a little earlier than I would like to, only to have them experience an exacerbation of difficulty requiring readmission."

- "I think the handwriting is on the wall, however, that hospitals will keep "physician profiles" and from these may eventually determine that it is not profitable to keep certain physicians on the medical staffs."

- "Our administrator has initiated a system of yellow and red stickers to be placed on the charts as the magic allotted figure nears consumption. It is very disconcerting to see these stickers on charts of patients who are critically ill and recently post-op. It's distressing that we are forced to live with a system that is so rigid that no allowance is made for complicating factors. The very idea that each disease can be standardized in each patient is preposterous."

- "I have been taught (by the hospitals) to rearrange and make the diagnoses with the highest weights listed down first. This did not matter much before the DRGs. There is now more paperwork, time lost in reviewing the chart and cost in implementing and overseeing the program. Many of the small things that I never placed before the DRG times, I have to place them now amongst the diagnoses to increase the weight and multiplier. Thus to justify the stay!"

We are concerned that examples like these represent only the tip of an iceberg -- initial symptoms of what could prove to be a massive problem with the PPS. We are concerned that further squeezes on Medicare reimbursement will only increase these situations to the point where they are no longer isolated instances of system failure.

Future Studies on the Quality of Care in PPS Hospitals

The AMA will continue to monitor the effects of the PPS through the DRG Monitoring Project and through the use of surveys. As part of the Association's 1985 Socioeconomic Monitoring System survey of physicians, questions were posed relating to readmissions, early discharges, and reductions in medical services because of the PPS. The survey results are as follows:

- Readmissions - Since the implementation of DRGs, 9.3 percent of the physicians stated that the average number of their Medicare patient readmissions had increased, while 6.8 percent of the physicians reported a decrease in readmissions. The remaining 83.9 percent of the physicians reported that the average number of their Medicare patient readmissions had not been affected.

During their most recent complete month of practice, 34.6 percent of the physicians readmitted one or more Medicare patients for a complication or continuation of an illness, while 9.9 percent of the physicians readmitted five or more patients. The remaining 65.4 percent of the physicians did not readmit any of their Medicare patients for a complication or continuation of an illness.

- o Early Discharges - 40 percent of the physicians reported that they have discharged Medicare patients from hospitals earlier than they had before the implementation of DRGs. 59.6 percent of the physicians stated that they are discharging Medicare patients at the same time, while 0.4 percent of the physicians reported that their patients are being discharged later than before.

  Of the 40 percent of the physicians who stated that they have discharged Medicare patients from the hospital earlier under the DRG system, 39.2 percent of these physicians reported that the earlier discharges have worsened the health status of their patients, while only 0.5 percent of the physicians stated that their patients' health status improved due to the earlier discharges.

- o Reductions in Medical Services - 21.8 percent of the physicians reported that their hospitals had responded to the PPS by implementing programs to reduce the number of medical services provided to Medicare inpatients.

  Of the 21.8 percent of the physicians who reported that their hospitals had implemented such programs, 39.2 reported that some of the reductions in medical services were in intensive care usage.

In addition to the collection of this type of survey data, the AMA currently is working with Johns Hopkins University to develop a series of research proposals that could result in a multi-faceted study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries. The stated objective for this project is to "assess various impacts of the Medicare prospective payment system on the quality and utilization of health care using a variety of case mix methods." We are still seeking funding for this important project.

S. 2331 - Medicare Quality Protection Act of 1986

S. 2331 contains a number of provisions that are intended to address many of the quality of care problems created by the PPS. The AMA supports the goals of S. 2331 and many of its provisions. Specifically, we strongly support requiring the Secretary of Health and Human Services to develop a legislative proposal which would refine the PPS to better account for variations in severity of illness and case complexity. Such a modification would result in more equitable hospital payments and thereby reduce the pressure on physicians to discharge patients prematurely.

The AMA also strongly supports a study of the need for a separate payment to hospitals for continued inpatient stay necessitated by delays in obtaining placement of beneficiaries in appropriate post-hospital extended care facilities. Such a payment would be appropriate to help ensure that patients can be properly cared for until post-hospital care becomes available.

In addition, we support the provision that would require hospitals, as a Medicare condition of participation, to establish a discharge planning process that meets appropriate guidelines and standards. This provision recognizes that discharge planning is a key element in providing quality patient care.

The AMA believes, however, that some of the provisions of S. 2331 need modification in order to ensure that the interests of Medicare beneficiaries, physicians and hospitals are adequately safeguarded.

Our detailed comments concerning S. 2331 are included as Appendix B to our statement.

Conclusion

Mr. Chairman, the AMA is concerned about the potential for deterioration in the quality of health care available in this country. Our concerns are heightened by the fact that Medicare has repeatedly been targeted for cuts, freezes and major program modifications in the budget process. We strongly believe that the Medicare program must be allowed to operate in a rational manner to assure the availability of a quality health care system for the growing numbers of elderly Americans.

Mr. Chairman, in the interests of the elderly patients of this country, I am compelled to place squarely before this Committee a growing concern among the nation's physicians who treat Medicare patients. While physicians have been trained to be advocates for and protectors of their patients' health, physicians are increasingly being pushed into the uncomfortable and objectionable role of being the advocate for and the protector of the federal budget. Physicians who err on the side of patient advocacy are, at a minimum, subject to challenge; at worst, they are subject to severe sanctions.

To date, physicians have resisted the mounting pressures to discharge patients prematurely. However, we remain deeply concerned particularly regarding cases in which continued hospitalization is not clearcut. In such cases, we believe the physician should err on the side of the patient without fear of recrimination or penalty.

We hope there will be a return to support by the Congress for strengthening the physician advocacy role for the patient and remove the compromising climate that surrounds the patient care setting. If

Congress continues to use Medicare as a primary focus of domestic budget savings, it will emphasize the point that cost concerns dictate the availability of health and medical services for the elderly.

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APPENDIX A

REPORT OF THE BOARD OF TRUSTEES

Report: R
(I-85)

Subject:	AMA's DRG Monitoring Project and the Prospective Pricing System
Presented by:	William S. Hotchkiss, M.D., Chairman
Referred to:	Reference Committee G (Ed L. Calhoon, M.D., Chairman)

At the 1984 Interim Meeting, the House of Delegates adopted Board of Trustees Report FF which contained early responses to the AMA's DRG Monitoring Project. Report FF outlined not only major physician concerns, but also contained an update on the Prospective Pricing System (PPS), and identified some of the Association's activities in this area.

The following report is intended to provide the House of Delegates with an updated discussion of the impact of the PPS based upon responses received by the DRG Monitoring Project through August 31, 1985. A summary of the current status and changes in the PPS are also included.

CURRENT STATUS OF THE PPS

Hospitals Affected

All hospitals which were expected to operate under PPS are now doing so. This represents a total of 5,405 or 81 percent of all hospitals participating in the Medicare program. The remaining 1,246 or approximately 19 percent of the hospitals participating in Medicare are exempted from the PPS. These include:

- 555 Short-stay hospitals in waivered states
- 464 Psychiatric hospitals
- 88 Long-term care hospitals
- 63 Rehabilitation hospitals
- 49 Children's hospitals
- 27 Alcohol/drug hospitals

In addition, 762 psychiatric units, 373 rehabilitation units and 314 alcohol/drug treatment units in acute care hospitals are currently exempted from the system.

Past House Action: I-84:154-161; A-84:342,344,348; I-83:200-201; A-83:109-111,195-202,317-318;I-82:35-40,281; A-80:178-181

Hospital Admissions

According to the August 1985 Health Care Financing Administration (HCFA) Background Paper, there were approximately 6.5 million Medicare short-stay hospital admissions from October 1, 1984 through April 30, 1985. This represents a decrease of 5.4 percent for the same period in fiscal year (FY) 1984.

The Professional Standards Review Organizations (PSROs) and the Peer Review Organizations (PROs) have continued to examine a percentage of Medicare hospital admissions and discharges. As of May 31, 1985, 32 percent of all PPS admissions have been reviewed, resulting in the denial of payment of 2.6 percent of the reviewed admissions. In FY 1984, 32 percent of all PPS admissions were also reviewed. Payment was denied for 2.8 percent of those reviewed admissions.

Length of Stay

From October 1, 1984, through April 30, 1985, the average length of stay (LOS) for Medicare patients in PPS short-stay hospitals was 7.7 days, which is slightly higher than the 7.6 days for the same period in FY 1984. The average LOS for Medicare patients in all short-stay hospitals, including exempted hospitals, was 9.0 days in FY 1984. In addition, HCFA notes that comparisons between FY 1984 and FY 1985 are difficult because of the geographic variation of PPS phase-in during FY 1984 and a lack of a complete year's worth of data in FY 1985.

Ten Most Common DRGs

Table 1 presents the ten most common diagnosis related groupings into which discharges have been classified through July 28, 1985, as reported by HCFA. These "top ten" DRGs have accounted for 29 percent of all PPS discharges during the current fiscal year. As can be noted in Table 1, there is a year-to-year fluctuation in DRG ranks. For example, while DRG 96 (Bronchitis and Asthma) moved from twelfth place in FY 1984 to sixth place in FY 1985, DRG 39 (Lens Procedures) dropped from third place in FY 1984 to eleventh place in FY 1985.

CHANGES IN THE PPS

HCFA has continued to receive recommendations for PPS modifications from the AMA and other health care organizations. Based on these recommendations and due to experiences with the system, HCFA was expected to implement the following changes, effective October 1, 1985.

Payment Rates

In analyzing the combined effect of the forecasted increase in the hospital market basket, the proposed composite factor, and the proposed composite policy target adjustment factor, HCFA concluded that the FY 1986 payment level should be 4.42% below the existing payment level. However, in its scheduled PPS rule change, HCFA will set the FY 1986 standardized payment rates at the same level as the FY 1985 payment rates.

Hospitals Affected

The states of Massachusetts and New York will not seek renewal of their waivers which currently exclude them from the Medicare PPS. Effective October 1, 1985, Massachusetts will be included in the PPS, as will New York, effective January 1, 1986.

TABLE 1
PROSPECTIVE PAYMENT SYSTEM MONITORING
TEN MOST COMMON DRGs
October 1, 1984 through July 28, 1985

FY85 Rank	FY84 Rank	DRG No.	Description	Discharges	Percent of Discharges
1	1	127	Heart Failure and Shock	210,720	5.2
2	6	089	Simple Pneumonia and Pleurisy	163,987	4.1
3	5	140	Angina Pectoris	134,623	3.3
4	2	182	Esophagitis, Gastroenteritis, Misc. Digestive Disorders	133,011	3.3
5	4	014	Specific Cerebrovascular Disorders	126,148	3.1
6	12	096	Bronchitis and Asthma	89,829	2.2
7	8	138	Cardiac Arrhythmia & Conduction Disorders	85,769	2.1
8	10	296	Nutritional and Misc. Metabolic Disorders	81,887	2.0
9	9	088	Chronic Obstructive Pulmonary Disease	74,910	1.9
10	7	243	Medical Back Problems	71,866	1.8

SOURCE: Health Care Financing Administration

DRG Reclassifications

HCFA was expected to implement the following DRG changes effective October 1, 1985:

- Bilateral Joint Procedures - In the first DRG Monitoring Project Report, the Board of Trustees reported that many physicians were concerned with inadequate reimbursement for bilateral knee and hip replacements which were classified under DRG 209 (Major Joint Procedures). HCFA has created

DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) to encompass certain combinations of major joint procedures within DRG 209 that may be performed during the same hospital stay. Any bilateral knee and/or hip replacements that are performed during the same hospital stay will now be assigned to DRG 471. In general, payments for these procedures will be increased under DRG 471.

- Kidney Transplants for Diabetic Patients - Diabetic patients with end stage renal disease (ESRD) who receive kidney transplants are currently classified into DRG 468 (Unrelated O.R. Procedures). However, according to HCFA, since these patients required the clinical services and resources described for DRG 302 (Kidney Transplant), diabetic ERSD patients who receive kidney transplants will now be classified into DRG 302. In general, payments for kidney transplants will be increased under this reclassification.

- Alcohol and Drug Abuse DRGs - According to HCFA, the content and relative weights of DRGs 433-437 have been revised and recalibrated to accurately account for resources utilized in these DRGs. HCFA believes that these DRGs will provide a better means of distinguishing the cases in which substance abuse results in hospitalization and cases in which substance abuse requires both detoxification and rehabilitation care. The substance abuse cases will now be classified into the following DRGs:

  -DRG 433 - Substance Use and Substance Induced Organic Medical Disorders, Left Against Medical Advice.

  -DRG 434 - Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence.

  -DRG 435 - Substance Dependence, Detoxification and/or other Symptomatic Treatment.

  -DRG 436 - Substance Dependence, Rehabilitation Therapy.

  -DRG 437 - Substance Dependence, Combined Rehabilitation and Detoxification Therapy.

At this time, any changes in payments under revised DRGs 433-437 cannot be estimated.

Recalibration of DRG Weights

The DRG relative weights currently used by the PPS are based on 1981 hospital operating cost information and data. For FY 1986, HCFA has recalibrated the DRG weights utilizing actual charge data set forth in the FY 1984 data set. Besides being more recent, this data was derived from 100 percent of FY 1984 Medicare hospital discharges, compared to the FY 1981 data which consisted of a 20 percent sample of Part A inpatient hospital bills.

In addition, many physicians have raised concerns that reimbursement payments are not adequate for cardiac pacemaker implantations (DRGs 115-118), intraocular lens procedures (DRG 39), and infective endocarditis (DRG 126). While HCFA has not selectively revised these DRGs, they have recalibrated the relative weights based on the FY 1984 data. Except for DRG 117, the relative weights for all the above DRGs will increase in FY 1986.

Outliers

The PPS has continued to authorize additional payments for atypical or "outlier" cases, which are defined as cases involving an unusually long length of stay (day outlier) or cases in which the costs are substantially above the DRG rate (cost outlier). Scheduled HCFA modifications for all DRGs include increasing the threshold for cost outliers from $13,000 to $13,500 and decreasing the length of stay outlier criteria from 22 to 17 days.

DRG MONITORING PROJECT

Purpose

The AMA's DRG Monitoring Project was designed as an information assessment activity to elicit reactions and comments from physicians on the impact of the PPS in their hospitals, and to identify "problem" areas that may necessitate further study. The information obtained from the project has been, and continues to be, instrumental in developing congressional testimony, formulating policy and seeking modifications in the PPS, and providing input into scientific studies.

Implementation

The DRG Monitoring Project was implemented in June 1984. During the past 16 months, the AMA has elicited physician responses through letters written to the chiefs of medical staffs in all U.S. hospitals on the PPS, and through advertisements in AM News and JAMA. Several state medical associations, national medical specialty societies, and hospital medical staffs have also promoted the project through their newsletters.

Status

As of August 31, 1985, 389 written responses representing approximately 7800 physicians have been received by the AMA. Comments were provided by physicians in 40 states, 20 different medical specialties, teaching and nonteaching institutions, and urban and rural areas. A majority of the responses were received from chiefs of medical staffs who incorporated the comments of their entire medical staffs. Several chiefs of staffs conducted their own surveys and forwarded the results to the DRG Monitoring Project.

The majority of responses presented views on several issues and a number contained detailed supporting documentation. The areas of most common concern were:

- Quality of care
- Costs of care
- Length of stay
- Admission/discharge policies
- Administrative relations

A summary of these categories is presented below.

Quality of Care

Of the comments received concerning quality of care, 66 percent stated that the quality had deteriorated, while 34 percent stated that the quality had either improved or remained the same.

One major concern encountered by many physicians involves hospital stays in which a second patient condition or complication also requires treatment. Some physicians reported that they have been discouraged from providing immediate treatment for a second condition, because the hospital may not receive additional reimbursement for a second procedure.

Some physicians also expressed concerns over the effect that early discharges may have on the health care of patients. Many physicians face the dilemma of either prolonging their patients' length of stay, or discharging them to alternative health care facilities. According to one respondent:

> "a number of patients we have had have been forced in a certain respect to go into (an alternative health care facility) from the hospital because they have not been able to go home yet and should have remained in the hospital, but could not because of marked overextension of their health care costs. I do feel some of these patients are receiving a lesser quality of care than other patients."

Another concern involved administrative "pressure" to place limitations on laboratory tests and procedures. Many physicians reported that quality of care may be affected by a decrease in the use of laboratory tests necessary for proper diagnosis. In the words of one respondent:

> "Eventually the quality issue will focus on underutilization of the necessities of care by all providers (physicians and hospitals) versus the overutilization of the past."

Cost of Care

Of the comments received regarding the cost of care, 85 percent reported that reimbursement to their hospitals was inadequate for one or more DRGs. Fifteen percent of the comments stated that either the hospital has not lost money through DRG reimbursement, or the hospital was able to bring costs in line with reimbursement. Major areas of concern continue to be that: (1) severity of illness is not appropriately accounted for in DRGs; (2) small or rural hospitals are continuing to experience losses on DRGs; (3) bilateral hip and knee replacements have the same reimbursement as unilateral procedures; and (4) reimbursement is inadequate for cardiac pacemakers, lens procedures, and treatment for infective endocarditis.

Length of Stay

Of the comments received regarding length of stay (LOS), 65 percent of the respondents stated that LOS had decreased under the PPS, while 10 percent said that there had been no change in LOS. The remaining 25 percent of the respondents did not acknowledge a change in LOS, but questioned the appropriateness of LOS for certain DRGs. Some of these include:

- DRG 8 (Surgery on Cranial Nerves, over age 70 - mean LOS of 4.1 days)
- DRG 11 (Nervous System Neoplasms, under age 70 - mean LOS of 8.5 days)
- DRG 29 (Traumatic Stupor plus Coma, one-hour - mean LOS of 3.8 days)

Admission/Discharge Policies

Of the comments received concerning admission and discharge policies, 43 percent reported that there was pressure to discharge patients early, 32 percent stated that policies had changed for the better, and the remaining 25 percent stated that they have not noticed a change in hospital discharge policies.

The presumed reason behind early discharges involves keeping the LOS at the mean LOS for most DRGs, thus enabling the hospital to maintain "break even" reimbursement. While some physicians have reported favorable influences by emphasizing preadmission testing and discharges to home care, others have questioned the quality of care when patients are discharged early to alternative health care facilities.

Administrative Relations

Of the letters received addressing administrative relations, 42 percent reported a deterioration in administration-physician relations, 30 percent reported no change, and 28 percent reported an improvement in relations. The negative comments related to administrative "pressures" to shorten LOS through early discharges; to delay treatment of secondary conditions or complications; to decrease the utilization of some laboratory tests; and to perform some procedures on an outpatient basis regardless of patient age and mobility. The positive comments related administrative efforts to develop medical education programs and literature on DRGs; to provide physicians with cost of treatment records comparing individual averages to medical staff averages; and to develop DRG committees comprised of physicians, administrators and ancillary hospital personnel.

Summary of Key Findings

The DRG Monitoring Project has continued to receive both positive and negative comments regarding the impact of the PPS on patients, hospitals and physicians. The areas which respondents identified as requiring further study include:

- The concern for deteriorating quality of care due to early discharges, limitations on laboratory tests, and hospital stays in which a second patient condition or complication requires treatment.

- The failure of DRGs to account for the severity of illness of individual patients.

- The continued financial risks faced by small and rural hospitals.

- The average LOS continues to be questioned for specific DRGs, such as traumatic stupor plus coma, surgery on cranial nerves, and nervous system neoplasms.

Positive comments have noted some instances in which costs have been cut and quality of care retained through the use of outpatient treatment, preadmission testing and discharges to home health care. Other comments have reported a positive effect that the PPS has had on improving communication between administrators and physicians.

FUTURE ACTIVITIES BASED ON THE DRG MONITORING PROJECT

The DRG Monitoring Project will be an ongoing activity throughout the final year of the PPS phase-in. The Board of Trustees urges physicians to continue to report their experiences to the following address:

AMA's DRG Monitoring Project
Department of Health Care Resources
P.O. Box 10947
Chicago, Illinois 60610

The information will be used to:

- Identify the particular problem areas which have been, and will continue to be, forwarded to HCFA, utilized in congressional testimony, etc.
- Provide background information for a proposed joint AMA-Johns Hopkins University study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries.
- Aid in the continued development of policy initiatives and programs for physicians and patients.

The Board of Trustees will report to the House of Delegates on future DRG Monitoring Project findings.

Appendix B

Detailed Comments Concerning S. 2331, "Medicare Quality Protection Act of 1986"

> Refinement of the Prospective Pricing System - The Secretary of Health and Human Services (Secretary) would be required to develop and submit to Congress by January 1, 1988, a legislative proposal to refine the PPS to better account for variations in severity of illness and case complexity.

The AMA strongly supports this provision. Adjustments to the PPS to reflect complexity and severity should result in more equitable hospital payments and provide relief to hospitals that attract a large percentage of severely ill patients. Such a modification would moderate pressures on hospitals to underprovide services and hospital pressures on physicians to discharge patients prematurely.

> Requiring Notice of Hospital Discharge Rights - Soon after admission, hospitals would be required to provide Medicare beneficiaries with a detailed written statement of their rights with regard to hospital and post-hospital care including their right to appeal a hospital notice denying benefits for continued inpatient services.

Providing Medicare beneficiaries with a notice would inform them of their rights resulting in greater participation in responsibility for patient care and treatment decisions.

> PRO Review of Hospital Denial Notices - This provision would authorize peer review organizations (PROs) to review cases where the patient disagrees with a determination made by both the hospital and the patient's physician that the patient no longer needs to be hospitalized. If a patient requests PRO review within one day of receiving the notice of denial of continued stay, the hospital would be prohibited from charging the patient for the first three days after receipt of the notice. (Current law allows charges to begin after two days.) The PRO would be required to provide notice of its decision to the patient within two calendar days.

This provision addresses the situation that arises under existing regulations in which beneficiaries may be liable for at least one day of hospital cost if they, in good faith, appeal a hospital denial notice and lose. Patients should not be financially penalized if they in good faith appeal a hospital denial notice and lose. However, we are concerned that this provision could unfairly subject hospitals to financial losses in cases in which the PRO decides that the denial notice was appropriate. As a result, we recommend that the bill be amended to provide for a special outlier payment for hospitals in cases in which a beneficiary loses an appeal of a denial notice and is not charged for the additional days.

> Prohibition of Certain Physician Incentive Plans - Hospital incentive plans that involve payments, directly or indirectly, to physicians for meeting specific length-of-stay or per-case cost targets for individual patients would be prohibited. Physicians and hospitals that violate the prohibition would be subject to civil monetary penalties.

The AMA supports the intent of this provision. Plans that provide financial incentives to underprovide services are unethical and should be prohibited. We are concerned, however, that this provision is overly broad and could be interpreted to apply to certain legitimate practices designed to promote efficient utilization of hospital and other health care services. For example, we doubt that the intent of this provision is to prohibit HMOs from distributing profits attained through a low hospital utilization rate. While such a plan is based on aggregate savings, the savings are generated on a patient-by-patient basis. We suggest that this provision be clarified to address this concern.

> Review of Quality Assurance Standards - The Secretary would be required to study the adequacy of the quality assurance standards used for hospitals for purposes of meeting the Medicare conditions of participation.

The AMA believes that a study should be conducted to determine whether hospital quality assurance standards are appropriate given the advent of the PPS. Such a study should be done through the Joint Commission on Accreditation of Hospitals (JCAH). The use of JCAH would ensure that the experience of the medical and hospital communities is utilized in the study and revision process.

> Administratively Necessary Days - The Secretary would be required to study the need for a separate payment to hospitals (in addition to the basic prospective payment amount) for continued inpatient stay necessitated by delays in obtaining placement of beneficiaries in appropriate post-hospital extended care facilities.

We strongly support this provision. An extra payment to hospitals for administratively necessary days would be appropriate to help ensure that patients receive appropriate care until less costly but appropriate care becomes available.

> Discharge Planning Requirement - Hospitals would be required, as a Medicare condition of participation, to establish a discharge planning process that meets guidelines and standards established by the Secretary.

The AMA supports this provision. Discharge planning is an important element in providing quality patient care.

> Waiver of Liability - The favorable presumption of waiver of liability for skilled nursing facilities and home health agencies would be continued if specified conditions are satisfied. The favorable presumption could be rebutted by actual or imputed knowledge of certain factors.

Without the favorable presumption, skilled nursing facilities could be reluctant to admit patients in cases in which it is not clear that Medicare will provide coverage. We support this provision.

> Expedited Review by Fiscal Intermediaries - The Secretary would be required to develop procedures to expedite the handling and disposition of claims for post-hospital extended care services and home health services.

We support this provision and recommend that it be expanded to cover all Medicare claims including hospital and physician services as well as post-hospital services.

> Provider Representation of Beneficiaries on Appeals - Providers would be permitted to represent beneficiaries on appeals.

The AMA has long supported allowing providers to represent beneficiaries in their appeals of Medicare coverage decisions. We also urge the Committee to adopt provisions to allow appeal of part B determinations. Such a provision was unfortunately dropped from the 1985 budget reconciliation bill (P.L. 99-272) in conference.

> Sharing of Confidential Information - PROs would, upon request, be required to share confidential information with national accrediting bodies and state ombudsmen and other state protection and advocacy officials. The PRO would be allowed to share such information to the extent that it relates to the quality of care furnished by a provider or practitioner and if the PRO determines that the information may reflect a failure to provide quality medical services.

The AMA opposes this provision because it would permit a PRO to share confidential information before the PRO has conducted a complete investigation of a possible quality problem. In such cases, the professional reputation of the practitioner or institution would be put into severe jeopardy without appropriate due process. We also believe that the appropriate state officials to receive confidential information are the members of state licensing boards, who have discipline authority through state licensure laws.

Other Items of Concern

We believe that the following provisions of the bill should not be adopted or need modification:

> Requiring PROs to spend a "reasonable proportion" of their time reviewing quality - This provision would imply that the majority of PRO activity is properly directed at cost measures. While federal directives have forced PROs to emphasize cost containment, we believe PROs should focus virtually all of their activities on quality assurance.
>
> Requiring information on the quality of post-hospital care in each annual PPS report - Information on the quality of post-hospital care should be gathered by a qualified private sector organization rather than by the federal government.
>
> Requiring PROs to review a sample of readmissions that occur within 30 days of discharge - The new PRO Scope of Work will require PROs to review all readmissions that occur within 15 days of discharge. It is currently optional for PROs to initiate additional readmission reviews. We do not believe that additional required reviews would be cost-effective.
>
> Requiring PROs to investigate all written complaints about quality filed by a beneficiary - While PROs should make every effort to investigate written complaints, this requirement could prove to be impossible to meet particularly without a substantial increase in PRO funding.
>
> Requiring PROs to have at least one consumer representative on its board of directors - While many PROs have a consumer representative on their board, we do not believe this should be a requirement.
>
> Requiring that a study be conducted to serve as the basis for establishing a long-term strategy for assuring and reviewing quality - The bill should specify that such a study should be conducted by a qualified private sector organization.

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STATEMENT OF ANDREW WEBBER, EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION, WASHINGTON, DC

Mr. **WEBBER**. Thank you, Mr. Chairman. I am Andy Webber, executive vice president of the American Medical Peer Review Association. I am filling in today for Dr. Tom Dehn, AMPRA president, who sends his regrets. He is out sick. I think the instability of the PRO program might have transferred down to the individuals involved.

Let me begin by thanking you, Mr. Chairman, and other members of the committee, for holding this very important hearing today on quality of care issues. It goes without saying that quality of care has been at the forefront of AMPRA and its members' concerns, and explains their commitment and involvement in medical review activities. We are delighted that the issues of quality of care have resurfaced again in the national health care policy debate, and it is no surprise, given the incentives of the prospective payment system. But as you have heard today, the issues of quality have always been before the Medicare Program, even absent the new incentives of the prospective payment system.

It has been the observation of PRO's after 2 years of experience, that for cases under their review, and as Senator Heinz has mentioned, PRO's are only looking at "a snapshot of care," that is, inpatient care is generally good and that we have not seen consistent patterns of compromised care; but as you will hear from Dr. Moncrief from California, and you have heard from Senator Heinz on many occasions, we have uncovered both instances of premature discharge and poor clinical management.

This identification of poor quality care coupled with the fiscal pressures to reduce the Federal Medicare outlays is a strong reason why we should commit ourselves to building a strong medical review program. AMPRA believes that such an effort, one, should be paid by the Federal Government; two, should be independent of the providers that are being reviewed; three, should maintain an element of local peer review; and, four, review the complete continuum of care rather than just a fragmented element of care.

AMPRA's second point, Mr. Chairman, is that, together with HCFA, we think we are making progress in building a comprehensive quality assurance effort. Although anyone looking at the original design of the PRO scope of work, I think, would agree that the focus initially was on cost containment rather than quality assurance, but happily with the new scope of work, we will be applying generic discharge and quality screens; we are going to be expanding our look at readmissions to 15 days from 7; we will start developing beneficiary outreach programs. And thanks to the new COBRA provisions, we will be expanding our review into HMO's, CMP's, ambulatory surgery, and potentially looking at skilled nursing facilities and home health agencies.

AMPRA would like to make the point that quality review is more expensive. It is going to take more physician time. It is going to take more nurse time. And it has been our observation in negotiating for the second round of contracts with the Health Care Financing Administration that they are offering the same or fewer dollars than they did in the original contract. So, we have concerns about whether we have the necessary resources to really take on that intensive look at quality of care.

Our third point, Mr. Chairman, is that we understand that Congress is reluctant at times to get involved in program management issues, but I feel compelled to speak out for our membership and say that, while there is instability in the program, some of it might be caused by program management issues. We have been frustrated by frequent program instructions without timely contract modifications. We have been frustrated by a very prescriptive review plan, and at times, often rigid and unnecessary oversight by the Health Care Financing Administration's regional offices. I know the intent of your legislation, Mr. Chairman, was to create flexibility in the program and let PRO's innovate. And finally, we are frustrated by the current evaluation of the program. You have heard a lot about the poor performance of PRO's. We are here not to say that every PRO is performing well, but we are here to search for answers to two central questions. No. 1, what is the PRO purpose? Is it cost containment? Is it quality assurance? Is it prosecution of offending providers? And second, what are the measurement tools for PRO performance? Is it simply our ability to deny payment? Are we simply going to count up denials and the number of sanctions that we have as the measure of performance? Or are we going to look at the ability of PRO's to prevent inappropriate action or behavior from happening? We are in search for answers to those questions.

Finally, we are in support of the Heinz-Stark bill. But as you have heard today, beefing up the quality assurance effort doesn't address the more central issue of creating benefits for long-term care and postacute care. Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you. Dr. Moncrief?

[The prepared written statement of Dr. Dehn follows:]

STATEMENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION

BEFORE THE SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

ON

QUALITY OF CARE UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

Presented by: Thomas G. Dehn, M.D.
President, AMPRA

June 3, 1986

EXECUTIVE SUMMARY OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION

1. THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION (AMPRA), REPRESENTING PEER REVIEW ORGANIZATIONS (PROs) AND OTHER PHYSICIAN BASED MEDICAL REVIEW ENTITIES, IS CONCERNED WITH THE IMPACT OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) ON THE QUALITY OF PATIENT CARE. THE PUBLIC PROMISE TO PROVIDE HIGH QUALITY MEDICAL CARE SERVICES TO THE ELDERLY MUST NOT BE COMPROMISED IN AN EFFORT TO REDUCE THE FEDERAL DEFICIT.

2. AMPRA IS ENCOURAGED TO HEAR FROM ITS MEMBER PROs AROUND THE COUNTRY THAT, FOR CASES UNDER PRO REVIEW, THE QUALITY OF PATIENT CARE IN HOSPITALS IS GENERALLY GOOD, WITH NO EVIDENCE OF CONSISTENT PATTERNS OF COMPROMISED CARE. PROs HAVE DETECTED INDIVIDUAL INSTANCES OF PREMATURE DISCHARGE AND CLINICAL MISMANAGEMENT. THIS EVIDENCE OF SERIOUS HARM TO PATIENTS COUPLED WITH CONTINUED FISCAL PRESSURE TO REDUCE DEFICITS SHOULD ONLY STRENGTHEN THE PUBLIC'S RESOLVE TO BUILD A STRONG AND EFFECTIVE MEDICAL REVIEW PROGRAM.

3. AMPRA BELIEVES THAT THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) IS MAKING PROGRESS TOWARDS DEVELOPING A COMPREHENSIVE REVIEW EFFORT. AMPRA ENDORSES THE MANDATE FOR THE SECOND ROUND OF CONTRACTS THAT PROs REVIEW ALL READMISSIONS WITHIN 15 DAYS OF DISCHARGE, APPLY A UNIFORM DISCHARGE AND QUALITY SCREEN TO EVERY RECORD UNDER REVIEW AND ESTABLISH A MEDICARE BENEFICIARY OUTREACH PROGRAM. THIS WILL BETTER BALANCE THE UTILIZATION AND QUALITY FOCUS OF PRO REVIEW AND HELP BUILD A COMPARABLE AND NATIONWIDE BASELINE OF IDENTIFIED QUALITY CONCERNS. AMPRA'S ENTHUSIASM IS TEMPERED BY THE RECOGNITION THAT QUALITY REVIEW AND BENEFICIARY COMMUNICATION IS EXPENSIVE AND THE OBSERVATION THAT PROS ARE BEING OFFERED FEWER DOLLARS FROM HCFA FOR THE SECOND ROUND OF CONTRACTS. CONGRESS MUST BE PREPARED TO EXPLICITLY FUND QUALITY REVIEW AND ANY ADDITIONAL PRO ACTIVITIES THAT ARE MANDATED BY LAW.

4. THE FUTURE SUCCESS OF THE PRO PROGRAM IS DEPENDENT UPON SOUND AND CONSISTENT PROGRAM AND CONTRACT ADMINISTRATION, INCLUDING A FAIR EVALUATION OF PRO PERFORMANCE. AMPRA BELIEVES THAT HCFA HAS FAILED TO MEET THESE OBJECTIVES ADEQUATELY. NEW AND FREQUENT PROGRAM INSTRUCTIONS WITHOUT FORMAL CONTRACT MODIFICATIONS, RIGID AND UNNECESSARY OVERSIGHT BY HCFA REGIONAL OFFICES THAT CANNOT DISTINGUISH BETWEEN MINOR AND MAJOR PRO INFRACTIONS, AND THE ABSENCE OF A FORMAL EVALUATION PLAN CREATING UNCERTAINTY AND INSTABILITY IN THE PRO COMMUNITY HIGHLIGHT AMPRA'S PRESENT CONCERNS. CONGRESS COULD LEND HCFA NEEDED DIRECTION BY CLEARLY ARTICULATING THE PURPOSE OF THE PRO PROGRAM IN STATUTORY LANGUAGE.

5. THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION IS SUPPORTIVE OF THE MEDICARE QUALITY ASSURANCE ACT OF 1986. THE ACT IS RESPONSIVE TO GROWING CONCERNS REGARDING THE QUALITY OF PATIENT CARE AND WILL HELP RESTORE PUBLIC CONFIDENCE IN THE MEDICARE PROGRAM. AMPRA BELIEVES, HOWEVER, THAT ANY MEDICARE QUALITY ASSURANCE EFFORT WILL BE LIMITED BY THE PRESENT INADEQUACY OF THE POST-ACUTE CARE BENEFIT AND THE ABSENCE OF A MEDICARE LONG TERM CARE POLICY. NO QUALITY ASSURANCE SYSTEM CAN TAKE THE PLACE OF NEEDED BENEFIT COVERAGE MADE MORE PRONOUNCED BY THE IMPACT OF MEDICARE PROSPECTIVE PAYMENT (PPS). AMPRA URGES CONGRESS TO REDESIGN MEDICARE BENEFIT COVERAGE IN RECOGNITION OF CHANGING PATIENT DEMANDS AND TO SERVE AS THE UNDERPINNINGS OF A REALISTIC QUALITY ASSURANCE PROGRAM.

6. AMPRA IS GENERALLY SUPPORTIVE OF THE PRO RELATED PROVISIONS AS SPECIFIED IN THE ACT. WE ARE CONCERNED, HOWEVER, WITH ANY EXPANSION OF PRO ACTIVITIES WITHOUT A CORRESPONDING INCREASE IN PROGRAM DOLLARS.

Mr. Chairman, I am Thomas G. Dehn, M.D., President of the American Medical Peer Review Association (AMPRA) and a practicing physician from Milwaukee, Wisconsin. AMPRA is the national association of physician-based medical review entities and of the Peer Review Organizations (PROs) under contract to the Medicare program. We appreciate the opportunity to participate in these hearings and to renew our valuable and constructive relationship with this Committee and with you, Senator Durenberger.

Appearing before this Committee is for us a little like coming home. We are very grateful for the support and confidence you and other members have expressed for the peer review process and the critical role it plays in maintaining and enhancing the quality of care available to beneficiaries of the Medicare program. We recognize that these hearings represent a continuing interest in the work of PROs and an opportunity to explore ways to strengthen and expand our activities.

In recent months there has been considerable discussion of the effects of the prospective payment system (PPS) on the quality of care rendered to Medicare patients. You have been presented with reports from constituents suggesting that Medicare patients have been discharged too quickly from hospitals. A number of congressional hearings have been held at which witnesses have commented on the lack of appropriate services for the post-acute patient. And, you have seen reports concerning the decline in hospital admissions and the increase in re-admissions to hospitals.

All of these sources of information reflect a growing concern that the new financial incentives of the PPS may result in compromises in the quality of care. We believe that attention to this subject is appropriate. Our members are deeply involved in efforts to assess the quality and appropriateness of care, and to identify and correct departures from recognized standards of medical care. While we are prepared to acknowledge that some incidents of poor quality or unnecessary care have occurred, we do not have the data to support a conclusion that these breaches of quality are occurring more frequently than under our previous payment arrangements.

What we are more certain about is the very dramatic and relatively rapid change in medical practice, and the gaps in the post-hospital delivery system. Innovations in technology and new diagnostic and therapeutic modalities in combination with the new payment incentives are changing the ways we use hospital services and supporting the growth of services outside of the hospital setting. In many respects these changes have occurred more rapidly than our capacity to inform and educate the public and our patients. Thus, some of the anxiety and fear you may have seen is the result of changes in the way physicians treat illness and injury.

PROs and the Assessment of Quality

From the perspective of the PROs, we are still learning how to define and measure quality in this changing environment. In fact, our focus and priority as established in our original Scope of Work two years ago was on controlling utilization of hospital services. A review of the objectives set forth at that time reveals that cost containment through utilization objectives was our primary mission.

From the outset, Mr. Chairman, PROs have urged the Health Care Financing Administration (HCFA) to balance our mandate by including greater attention to quality of care assessments. We recommended the use of discharge screens to enable PROs to monitor the condition of patients at discharge. We suggested the use of pre-admission screens that would allow us to intervene before services are actually provided. We urged development of generic quality screening to permit PROs to focus on cases with a high probability for quality compromises. And we have urged the pilot testing of severity of illness measures to assess whether patients are getting better or worse as a result of clinical intervention.

In candor, Mr. Chairman, these recommendations are only just now evident in the instructions to PROs and in the design of the new Scope of Work for the next two year contract cycle. Thus, we do not have extensive experience with quality oriented review protocols. We do not have the baseline data that allows us to compare quality indicators in the pre- and post-PPS environment.

Our confidence is growing and we are optimistic that the kinds of activities in which we will be engaged over the next two years will ensure a much more intensive assessment of quality. For example, the quality of our data is improving. We are beginning to employ discharge screens that in combination with review of all hospital re-admissions within 15 days and a hospital adverse incident report will give us a much more comprehensive picture of patient outcomes. Our ability to intervene before treatment is provided will be greatly enhanced by our 100% pre-procedure review of selected, elective surgical procedures. These pre-procedure reviews will not only focus on whether the procedure should be performed in a hospital, but also whether it should be performed at all. Finally, we are beginning the task of developing criteria to assess the professional quality of services provided to Medicare patients, leading to denials for care that fails to meet professionally recognized standards of care.

Most of these new activities are the result of mandates included in the Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in April. We supported these modifications to the PRO program and want to express our appreciation for your efforts on behalf of this legislation. As you know, negotiations are in progress for the PRO contracts covering the next two years. Our chief concern at this point is some evidence that HCFA is unwilling to recognize fully the additional resources that will be required to conduct these vital quality review activities and the new mandate for the review of services provided by organizations with Medicare risk contracts -- HMOs and competitive medical plans.

In sum, Mr. Chairman, we do not believe that it is possible to make broad generalizations about the quality of care available to Medicare patients. There are instances of inappropriate admissions, premature discharges and services that are not medically necessary. We have taken corrective action where these circumstances have been identified, but we do not as yet have a baseline against which these occurrences can be evaluated. We expect that our emerging focus on quality assessment will permit us to make more definitive judgements in the years ahead.

PRO Operational Concerns

Mr. Chairman, we would like to offer some brief comments on certain aspects of the operation of the PRO program that have an effect on our ability to accomplish our mission. First, we are aware that Congress recognizes the necessity of matching resources with required functions. The conference report accompanying COBRA makes it clear that additional PRO review activities must be supported with additional contract funds. To date we have noted a singular lack of support for this position within the Administration. In our recent contract negotiations HCFA has typically offered the same or fewer dollars for a very much expanded PRO agenda.

We would like to request your reenforcement of our concerns with regard to this issue. If the Committee could express its support for additional financial commitments for the PRO contracts, our capacity to implement the new review mandates would be enhanced. The funds applied to this vital program still represent less than one fifth of one percent of program outlays.

Mr. Chairman, as the original author of the PRO statutory provisions, you were quite clear about the value of using fixed price contracts as a means of avoiding the prescriptive excesses of the past and as a way to hold PROs accountable for specific outcome objectives. Unfortunately, the administration of these contracts has been characterized by considerable modification to the original agreement. New policies and changes in operational requirements have been issued frequently by HCFA without any re-negotiation sessions and without any revision to the contract dollars. Further, HCFA has sought to penalize those PROs that managed a surplus from their initial contract by offsetting those amounts from funds made available under the new contracts.

Mr. Chairman, we do not believe that HCFA can have it both ways. Under fixed price contracts there must be a procedure through which both parties formally re-negotiate change orders that materially alter the original agreement. PROs must also not be expected to assume the full risk for under-bidding their contract while HCFA is able to recover all amounts above the PROs operational expenses.

One last comment concerning administration of the PRO program focuses on the evaluation methodology employed by HCFA. There is no more sensitive issue to the AMPRA membership than the evaluation of PRO performance. Nothing threatens the future of the PRO program more than the failure to articulate program expectations and the absence of a comprehensive and publicly articulated evaluation protocol. At the beginning of the PRO program we must ask the question: What is the PRO mission - cost containment? quality assurance? professional education? and How are PROs to be judged - impact measures? adherence to a prescribed review system? contract compliance?

AMPRA's sensitivity to the evaluation issue finds its genesis in the PSRO program. We remember all too well that the failure to ask ourselves these questions and develop a meaningful process to answer them was the single major factor in the program's demise. AMPRA fears that the PRO program may be headed for a similar fate. The signals are not comforting. At the outset of PRO contracts, we requested specific information concerning the criteria and scoring methodology for the evaluation of contract compliance. None has been made available. On July 31, 1984, the HCFA Administrator Carolyne Davis, Ph.D. testified before your Committee Mr. Chairman and stated and I quote, "Concern has been expressed that PROs will take an excessively regulatory approach, performing medical review on a case-by-case basis with an emphasis on denying admissions. I can assure you that the PROs and HCFA, will regard denials as failures of the system. The PROs will rely as much as possible on communication, education, and "hands-on" working with physicians and hospitals as problems are discovered." AMPRA and its membership applauded that statement and its promise of a fresh, new approach to evaluating the performance of peer review activities. It appears, two years later, a hollow promise. Recently, an important HCFA official was quoted as saying that PROs with low denial rates are "former" PROs. Of the first thirty PROs that have come up for contract renewal, nearly half have been sent letters of non-renewal. By HCFA's own admission, many of these letters did not detail the reasons for HCFA's conclusions and the first PROs were not permitted face to face meetings with PRO officials leaving them confused and frustrated. Great uncertainty has been created in the PRO community, impacting morale, and causing many of the best personnel in the program to leave.

It has also been AMPRA's observation of HCFA's evaluation, particularly the oversight performed by HCFA regional offices, that more attention has been focused on process related issues rather than the outcomes of review. AMPRA believes that it is less important how PROs manage their internal affairs or whether they have followed each instruction from HCFA than whether PROs are meeting their negotiated objectives and are able to identify and act on utilization and quality problems.

Mr. Chairman, the PRO statute called for greater flexibility in federal contract management to allow review organizations to be innovative without the burden of prescriptive mandates and continuous oversight. We urge that this flexibility be restored to the PRO program. And, as we move to the second phase of the PRO program it would be particularly helpful for our members to be appraised of the criteria and protocols for evaluation. This is a common practice for other contractors and we believe the PROs should not be an exception.

At this point in our testimony, Mr. Chairman, we would like to insert for the record the report of AMPRA's Task Force of PRO Implementation entitled, PROs: The Future Agenda. The Task Force Report includes AMPRA's critical analysis of the PRO program to date and our recommendations for the future direction of physician peer review efforts. AMPRA would greatly appreciate the Finance Committees' consideration of our recommended actions.

Medicare Quality Assurance Act

Now we would like to turn our attention to the provisions of S.2331, introduced by Senator Heinz and you, Mr. Chairman. First, we believe this bill includes an agenda of steps that can be taken to move us forward toward a more integrated approach to quality assurance and identifies certain mid-course corrections to our present payment and coverage policies than can minimize the potential for compromises in the quality of care of gaps in the delivery system. We believe that quality and cost-effectiveness can and must be complementary objectives.

I think all of us recognize, however, that an improved quality assurance system cannot substitute for the need to improve Medicare coverage outside the inpatient setting. At a time when PPS has stimulated demand for nursing home, home health and custodial care services, Medicare coverage remains essentially as it was designed twenty years ago. If Congress intends to maintain the quality of care of the Medicare population, the need to revise Medicare benefit coverage cannot be avoided.

The bill would impose new reporting requirements on hospitals to submit data necessary to facilitate medical reviews. This provision, while not creating a new data system, would assist PROs in establishing their potential review universe in a timely manner. Thus, PROs would be able to better anticipate the volume of reviews for a given period and allocate resources more appropriately. AMPRA supports this section.

AMPRA also supports the expansion of readmission reviews from the present seven day requirement to all readmissions within 30 days of discharge. Expanded readmission review will not take the place of PRO authority to monitor the quality of patient care outside the acute care setting. Readmission reviews are, however, a potential indicator of premature discharge and clinical mismanagement and AMPRA strongly encourages this approach. It must be recognized that this is a significant expansion of present PRO efforts which will require additional program funding.

We also want to call your attention to the provision requiring PROs to complete consideration of beneficiary appeals of notices of non-coverage within three calendar days. While we support a prompt and fair appeals process, it may not be possible to complete our reviews in a timely fashion if the necessary documentation is not furnished rapidly. Further, if the beneficiary appeal is logged at the close of a business week, it may not be possible to complete our consideration within three calendar days. We recommend that the time limit for responding to appeals begin after submission of the necessary data to the PRO and that three working days be substituted for three calendar days. If three calendar days is retained, it must be recognized that administrative costs for PROs will increase to support weekend operations.

We strongly support provisions in Section 302 of the S.2331 that mandate PROs to concentrate on quality review activities. AMPRA is concerned, however, that section 302 does not make clear congressional intent to extend PRO review to the post-acute care setting, ambulatory setting and for services provided by a health maintenance organization. While it could be argued that the present law has always granted PROs authority to review services beyond the acute care setting, this authority is obviously not compelling absent requisite funding and a willingness on the part of the Administration to move ahead.

AMPRA recommends that expanded PRO review become a Condition of Participation for Medicare providers and that an appropriate time frame for implementation be established in law. Only then will the present authority be implemented. For the reasons cited earlier, expansion of PRO review should be a high priority.

This bill also includes a provision directing PRO involvement in a complaint resolution process for beneficiaries. In some respects, this activity moves the program toward an ombudsman role that could divert significant resources away from medical review functions. We do want to hear about possible quality problems from physicians, hospitals, other health professionals and from beneficiaries and their families. However, we do have some concern that a significant number of complaints may not relate to quality of care issues. Further, we believe that the existing confidentiality regulations may limit our ability to report the findings of our investigations to the complainant.

We strongly support the provisions of S.2331 that allow the sharing of information concerning final determinations by PROs with regard to substandard quality of care by any provider of Medicare services. Our experience with the sanctions process is that other regulatory and accreditating bodies are often pursuing the same individuals or institutions and that our findings can be helpful in the completion of their investigations. So long as the information shared represents our final recommendation and preserves appropriately the confidentiality of the process, we feel this provision can assure proper coordination of medical review, licensing and other regulatory activities.

The provision requiring the appointment of a consumer representative to the boards of PROs is, in our opinion, not necessary. A growing number of PROs already include such an individual on their board in accordance with a policy recommended by AMPRA. However, we do not think it is appropriate for the statute to mandate the board composition of private review organizations. Certainly PROs ought to have the discretion and flexibility to select board members on the basis of the organization's needs and availability of individuals to serve. AMPRA is not opposed to consumer representation on PRO boards; we are opposed to a statutory mandate that dictates board composition for any private organization.

Other Provisions of S.2331 of Interest to PROs

In our review of the remaining sections of the S.2331, we want to particularly note the emphasis on improving access to post-acute services. Our experience to date strongly indicates that gaps in the availability of skilled nursing beds and home health services are serious problems. Often planning for discharge has not been adequate, and in other cases facilities or needed services are simply not available. The development of new tools to aid discharge planning and mandatory hospital programs can be an important contribution.

AMPRA supports refinement of the payment system to better account for variations in severity of illness and case complexity. We support this provision because it improves the precision of the payment system, and because it can help us monitor and evaluate the quality of patient care. Such a severity measure should be based on patient characteristics and clinical findings at or near hospital admission rather than at discharge. Severity assignment at admission would reduce payment inequities, create proper incentives for hospitals, and maximize the potential of the severity measure as a quality assessment tool.

An important complement to a severity measure is the study of medical practice variation through the conduct of small area analysis by PROs. AMPRA's corporate affiliate, the American Medical Review Research Center (AMRRC), has submitted a prospectus to HCFA and interested foundations to coordinate a broad educational effort involving the research community and practicing physicians in understanding local practice variation.

We would like to suggest that allowing providers to represent beneficiaries in appeals proceedings is troublesome from our perspective. It seems to us that in most instances the provider is in a conflict of interest situation which is difficult to overcome. Since providers are often at risk for the financial consequences of a coverage of payment denial, we believe it is difficult for them to represent beneficiaries impartially. In most instances the beneficiary is not liable for the cost of non-covered services, and providers have adequate appeal rights on their own behalf.

In the final title of S.2331, there are a series of studies on the future of quality assurance mechanisms, the allocation of resources for these purposes and the criteria and methods employed to conduct these activities. These are critically important tasks. We are anxious to participate and to advise the Department of Health and Human Services in each of these areas. Improvement to our current approaches to reviewing hospital care can be achieved, and much can be learned about cost-effective review of the quality of services in the ambulatory environment. We hope that this work is accorded a very high priority at the Department ahead of the enactment of this measure.

We intend that our comments on this legislation be considered as supportive of the primary thrust of the bill. While there are several areas as noted where we believe the bill can be strengthened, overall the bill represents a positive set of reforms that can enhance quality and improve the effectiveness of PROs.

Again, we want to express our thanks to you Mr. Chairman, and the other members of this Committee for your continuing commitment to the PRO program. We appreciate your invitation to participate in these hearings, and we look forward to working on our shared objectives. I will be glad to respond to any questions about our testimony that you or other members of the Committee may have.

STATEMENT OF WILLIAM H. MONCRIEF, JR., M.D., PRESIDENT, CALIFORNIA MEDICAL REVIEW, INC., SAN FRANCISCO, CA, AND VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION, WASHINGTON, DC

Dr. MONCRIEF. Senator Durenberger, I am Bill Moncrief, a practicing surgeon in San Francisco and head of the California PRO for California. It is certainly a pleasure to be here.

CMRI and its membership certainly supports the Heinz-Stark bill. A formal statement has been submitted, and in the interest of time and hopefully your questions, I will just make a few brief remarks about some of the comments and questions that have been asked by members of the committee.

I don't quite agree with Dr. Roper that a "seamless system" is the answer. Certainly, the HMO's and the CMP's, in my experience—certainly in California—do not have the resources to fund this continuum of care that is the concern that has spoken and addressed themselves to this morning.

I also, as a practicing physician and head of the largest PRO, have concerns about panels of physicians setting standards of quality of care. I think that panels of physicians should establish criteria for which nurses or some non-M.D. professionals can approve and accept—identify as acceptable—the care that has been given to a patient; but I think it is up to individual physicians or panels of physicians locally to identify whether that is good quality or appropriate quality of care. It changes, whether it is rural, whether it is urban, whether it is a tertiary care facility, whether it is a small community hospital. The quality of care that is rendered does change; and I have a lot of concern about panels of physicians setting up standards of quality on a national basis.

The Senator from Montana asked the question: What few things or what single thing can be done to improve the delivery of care currently? Senator Durenberger, I think education is the most important thing right now—educating not only the beneficiary, but physicians. The PPS system is almost 3 years old, but weekly I run into physicians in California that do not understand the PPS system.

And I think organized medicine has a great responsibility here to improve the education of the practitioners in delivering care under this system. It is complicated, but it can work. It can be made to work even easier, I think, if the practitioners understand it.

Certainly, there was poor quality of care before PPS. And I think that the need to identify and correct that is ongoing; and we in California are trying to do it. Senator Chafee asked about better discharge planning. In the old cost-reimbursement era, this was done while a patient was in the hospital, and it was done with a certain—there was no pressure. It was being done. Now, the pressure is on to get the patient out of the hospital, the hospital to realize and maximize its reimbursement, and the discharge planning is done frantically. It is done better in some institutions than in other institutions, but certainly we need more intensive, more thorough discharge planning.

I know in California we are probably the premier State for post-acute hospital care resources; but even then, it is difficult to get the patient into a postacute hospital care environment in some areas. But across the board, I would say that, if you have the money, it is there. And so, one of the pleas would be that certainly the Government should recognize in squeezing down the acute hospital stay its responsibility to funding the postacute hospital environment a little bit better.

Thank you, Senator, and I await your questions.

Senator Durenberger. Thank you very much, Dr. Moncrief. Louise Crooks?

STATEMENT OF LOUISE CROOKS, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WEST LAFAYETTE, IN

Ms. Crooks. Thank you, Mr. Chairman. I am Louise Crooks, and I am president-elect of the American Association of Retired Persons [AARP]. On behalf of AARP's 22 million members, I want to thank you for this opportunity to state the association's views on the quality of medical care in America.

Medicare's hospital prospective payment system dramatically shifted the way in which hospitals are paid for the provision of care to the elderly and the disabled. By paying a set amount for each beneficiary in a particular diagnostic category, regardless of the treatment actually provided, hospitals now face strong incentives to limit both the length of stay and intensity of care for their Medicare patients. In practice, problems arise under this new system.

Some hospitals may discharge their patients prematurely in a strictly medical sense, sending patients home or to other facilities while they are still in need of hospital care. A more common set of problems can also arise that fall outside the bounds of traditional measures of quality of care.

When patients who need posthospital care are discharged when no further treatment is available, the health of the patient may suffer in much the same way as if the discharge had been medically premature. In such cases, patients may be sent home only a few days after surgery with no one to provide support, to administer medications, or help change dressings.

These patients may not need expensive hospital care and may not have been inappropriately discharged in a medical sense. Rather, they suffer from a lack of a reasonable continuum of care that would offer skilled nursing services in another institutional setting or at home. Although on paper the Medicare Program offers home health care and skilled nursing facility services for such persons needing posthospital care, these services are often not available.

Early trends indicate that use of these two services, which together account for less than 3 percent of all Medicare spending, has not grown in response to earlier hospital discharges. The increases in Medical expenditures on home health and SNF care between 1983 and 1984 were at or below their recent average rates of growth. Too many Medicare patients continue to lack access to these services.

A basic quality assurance program must assure the continuity of care from one setting to another. The association strongly supports hospital discharge planning as a condition of participation in Medicare. A tight discharge planning program could protect patients and physicians alike by requiring that a patient's condition meet certain generic requirements for discharge and that an appropriate discharge designation is assured. The plan should be signed by the physician and become part of the patient's chart.

Practical considerations in this case, such as the lack of available skilled nursing care, must be reflected in the discharge plan and influence the discharge decision process.

The failure to accommodate patients requiring postacute care services is a major loophole in Medicare's scheme of care. Failure to address this gap in the continuum of care is having a profound negative effect on beneficiaries and the Medicare Program. A variety of mechanisms are available to alleviate this problem. One is to recalibrate the DRG's to increase the resources going to the dozen or so DRG's that account for most discharges to SNF's or HHA's.

A second way is the incorporation of a perfected severity-of-illness index. This index could be used as a measure for directing discharged patients to the appropriate level of care. And three, the concept of administratively necessary days, known as AND's, could be revitalized to accommodate patients needing postacute care when none is available. The association is proud to support the Medicare Quality Protection Act of 1986, S. 2331, drafted by Senator Heinz, and cosponsored by many of the members of this distinguished committee. Senate bill 2331 is an important step toward better quality care for Medicare patients.

AARP believes, however, that additional initiatives to make posthospital services reliable and predictable must be incorporated into the bill. Otherwise, the Medicare benefits will continue to erode along with confidence in the program. Briefly, Mr. Chairman, AARP believes that there are additional efforts which are necessary to improve the quality of our Nation's care for the delivery system, including a comprehensive data base and an aggressive research agenda on quality of care. In addition, consumer involvement in the Medicare Program must be assured by making all Medicare rules subject to the Administrative Procedures Act. Thank you.

Senator DURENBERGER. All right. Thank you very much.

[The prepared written statement of Ms. Crooks follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

SENATE FINANCE COMMITTEE

on

THE QUALITY OF MEDICAL CARE

Washington, D.C.
June 3, 1986

Presented by:
Louise Crooks
AARP President-elect

INTRODUCTION

Thank you, Mr. Chairman. My name is Louise Crooks and I am the President-elect of the American Association of Retired Persons. On behalf of AARP's 23 million members, I want to thank you for this opportunity to state the Association's views on the quality of medical care in America. Since retired persons use health care services at a rate three times greater than the under age 65 population, the quality of medical care is a major concern of our members.

My testimony today will describe some of the quality of care problems in Medicare, and make recommendations to shoreup the quality of Medicare and improve the quality of medical care throughout the system.

THE EMERGENCE OF QUALITY OF CARE PROBLEMS IN MEDICARE

Medicare's hospital prospective payment system dramatically shifted the way in which hospitals are paid for the provision of care to the elderly and disabled. By paying a set amount for each beneficiary in a particular diagnostic category, regardless of the treatment actually provided, hospitals now face strong incentives to limit both the length of stay and intensity of care for their Medicare patients. In theory, such a system should discourage the use of unnecessary tests and treatment and should shift patients who need less than acute care services into less intensive settings at the end of their hospital stay. Care would thus be delivered in the most efficient manner while patients would still receive needed services.

In practice, however, problems arise. In some cases the quality of care delivered in the hospital suffers. Some hospitals may discharge their patients prematurely in a strictly medical sense, sending patients home or to other facilities while they are still in need of hospital care. These are serious problems that need to be carefully monitored. Good quality control mechanisms are needed to ensure that quality is not allowed to deteriorate.

A second, and probably more common, set of problems can also arise, however, that fall outside the bounds of traditional measures of quality of care. When patients who need post-hospital care are discharged when no further treatment is available, the health of the patients may suffer in much the same way as if the discharge had been medically premature. In such cases, patients may be sent home only a few days after surgery with no one to provide support, to administer medications, or to help change dressings. Patients recovering from hip replacement surgery may not receive needed rehabilitation treatments. If they do not get needed care, their recoveries may take longer, or they may need to be readmitted to a hospital. In extreme cases, the patient may die.

These then are certainly problems affecting the overall quality of care. Before the advent of PPS, such patients might have stayed longer in the hospital. Now that option is less likely to be available. These patients do not need expensive hospital care and have not been inappropriately discharged in a medical sense. Rather, they suffer from the lack of a reasonable continuum of care that would offer skilled nursing services in another institutional setting or at home.

How large is this problem? While good information is still hard to find, the early results certainly suggest that the problem is potentially severe. The average length of an inpatient hospital stay fell by more than 10 percent between 1983 and 1984, the first year in which PPS was in effect. In fiscal year 1984 the average stay was 9 days--or more than 11 million hospital days less than if lengths of stay had remained unchanged from their 1983 levels. Not all of this decline can be attributed to PPS since there has been a long-term trend toward shorter hospital stays. Nonetheless, the 1984 decline occurred at a rate three times as high as in the recent past.

Moreover, the drops in the length of stays in hospitals have not just occurred for the simple cases; some of the largest declines have come in the diagnostic categories where the sickest patients are found. For example, the diagnostic category that covers hip procedures for persons age 70 or above includes many frail elderly who are likely to need further care after discharge. Between 1981 and 1984, the average length of a hospital stay for such Medicare patients fell by 18 percent as compared to a drop of just over 14 percent for all Medicare hospital stays over that period. Thus, many of the 11 million fewer hospital days affected the oldest, sickest patients.

Although on paper, the Medicare program offers home health care and skilled nursing facility services for such persons needing post-hospital care, these services are often not available. Early trends indicate that use of these two services, which together account for less than 3 percent of all Medicare spending, has not grown in response to earlier hospital discharges. The increases in Medicare expenditures on home health and SNF care between 1983 and 1984 were at or below their recent average rates of growth. Many Medicare patients continue to lack access to these services.

Patients needing further care thus may not be able to count on Medicare. As a result, patients will have to purchase such care on their own, rely on other public programs such as Medicaid, turn to relatives and friends for informal care, or do without.

IMPROVING THE QUALITY OF MEDICARE

Our nation's ability to better assure high quality medical care is directly related to our understanding of what a quality medical outcome is and our capability to promptly detect and correct unacceptable deviations from quality care. The fact of the matter is, however, that the country lacks adequate information about medical outcomes and the quality monitoring system necessary to promptly alert providers and policymakers to unacceptable care.

A properly designed quality assurance program must be comprehensive, covering all Medicare providers and sites of service including hospital inpatients and outpatients, physicians' offices, nursing homes, HMOs, home health agencies and hospices. There should be but one standard of care despite the method of delivering the care. The Association endorses the letter and spirit of the Consolidated Omnibus Budget Reconciliation Act's extension of PRO jurisdiction over

HMOs and urges Congress to extend PRO jurisdiction over all Medicare providers. PROs represent our national commitment to quality medical care and they must be permitted to develop the comprehensive monitoring system necessary to maintain that commitment.

Moreover, a basic quality assurance program must assure the continuity of care from one setting to another. The Association strongly supports the proposal to make hospital discharge planning a condition of participation in Medicare. An ironclad discharge planning screen could help assure that Medicare patients are discharged to an appropriate level of care, and it can be an effective mechanism for overcoming the perceived need to directly interfere with the traditional relationship of trust between doctors and patients under the prospective payment system.

Medicare patients are leaving the hospital sooner and sicker than in the past. Patients too sick to go home can appeal a discharge made by the hospital. A discharge by the attending physician, however, is not appealable under Medicare. Many believe that Medicare patients should have the right to appeal any discharge order, whether by the hospital or the physician. There is a growing body of evidence that physicians are bending under hospital pressure to discharge patients quicker. This pressure is reported by the major physician organizations. Moreover, the problem was exposed on national television when a Texas physician, appearing on the ABC television network news show "Nightline", said in no uncertain terms that he was coerced into discharging a patient too soon.

Opening all physician authorized discharges to challenge, however, would be a major break with traditional medical practice. The Association is reluctant to further jeopardize the trust basis of the doctor/patient relationship by calling for patients to appeal their physicians' discharge decisions. Nevertheless, the fear that physicians will increasingly bend to hospitals' pressures to get patients out quickly, strongly commends the need for greater procedural protection for the patient's right to stay in the hospital.

Implementation of an ironclad discharge planning screen could offer a far more constructive way to protect a patient's continuing care stay in the hospital. A tight discharge planning program could protect patients and physicians alike by requiring that their patient's condition meet certain generic requirements for discharge and that an appropriate discharge destination is assured. The plan should be signed by the physician and become part of the patient's chart. "Practical considerations" in the case (such as the lack of available skilled nursing care) must be reflected in the discharge plan and influence the decisionmaking process.

Similarly, AARP supports the development of a uniform needs assessment instrument to assist in evaluating Medicare and Medicaid beneficiaries' need for post-hospital care. A uniform needs assessment instrument for post-hospital care will provide needed information about patients that will be crucial to developing the kind of long-term care system necessary to meet the needs of a growing aged population.

Advance planning for discharge and uniform needs assessment for post-hospital services are essential to the maintenance of quality care under PPS. But, the best discharge planning in the world and the best needs assessment in the world cannot protect the continuum of care, and thus the quality of care to discharged patients, if the needed post-acute care services are not available. Failure to accommodate patients requiring post-acute care services is a major loophole in Medicare's scheme of care. The Association believes that the failure to address this gap in the continuum of care is having a profound negative impact on beneficiaries and the Medicare program.

The Association believes there are a variety of mechanisms available for alleviating this problem. Recalibration of the DRGs, with increased resources going to those dozen or so DRGs that account for most discharges to SNFs or HHAs would be a budget neutral method of assuring greater access to post-acute care services.

Perfection of a severity of illness index could be used as a measure for directing discharged patients to the appropriate level of care; or the concept of "administratively necessary days" (A.N.D.s) could be revitalized to accommodate patients needing post-acute care when none is available.

Prior to PPS, patients backed-up in hospitals awaiting placement in a skilled nursing facility were permitted to stay in the hospital until a SNF bed was available. Hospitals serving such patients were paid under the guise of providing A.N.D.s. Medicare payments to hospitals for A.N.D.s were incorporated into the DRG rate base. Nevertheless, hospitals under PPS have not kept patients awaiting a skilled nursing bed in the hospital. HCFA's failure to require hospitals to provide A.N.D.s to patients who cannot get appropriate post-acute care services is harming Medicare patients. In an era of cost containment, it is incongruous that HCFA would pay for care that is simply not being provided.

A similar situation obtains because of the operation of the so-called three day rule. Under current practice, a Medicare patient is not eligible for nursing home care unless the patient was in the hospital for three days prior to discharge to the nursing home. Under PPS entire categories of procedures have been limited to the outpatient setting. Patients recovering from outpatient surgery needing post-acute care services are now not eligible for such services because of the three day rule. The three day rule must be eliminated, or at least modified to accommodate the scores of Medicare outpatients needing post-acute care services.

THE MEDICARE QUALITY PROTECTION ACT OF 1986

The Association is proud to support the Medicare Quality Protection Act of 1986 (MQPA) (S.2331), drafted by Senator Heinz and cosponsored by many of the members of this distinguished committee. MQPA is an important step in the direction of better quality care for Medicare patients. AARP urges this committee to strengthen MQPA, however, by recognizing Medicare's failure to provide an adequate continuum of care for patients under PPS.

Initiatives to make necessary post-hospital services reliable and predictable must be incorporated into this bill. Otherwise, the Medicare benefit will continue to erode along with confidence in the program. The erosion of Medicare is an unfortunate, unnecessary, and unintended side effect of the new pricing mechanism. Correcting it does not constitute an expansion of benefits, but a maintenance of Medicare benefits as they have been understood for the past twenty years.

IMPROVING QUALITY IN THE HEALTH CARE SYSTEM

I. The need for data -

* PROs must be funded to support access to and integration of multiple data bases. The PROs analytic potential can only be enhanced by increased access to information systems beyond Part A claims data.
* Ways of presenting PRO-generated data in furtherance of the public interest in better informed consumers must be developed.

II. Research in quality of care

In the past, the commitment to quality health care was assumed by the presence of abundant resources. But skyrocketing health care costs shifted priorities to cost containment. The resultant DRG system established a new set of financial incentives. Accompanying the incentives to reduce the hospital cost of each inpatient stay is the incentive to undertreat. Grappling with the real and potential quality of care problems under the new system brought to light the need to know more about quality of care. To help focus that light, AARP supports the following research agenda:

- Longitudinal studies of patient care must be systematically conducted. Patient health care outcomes must be monitored over time with the focus on such areas as functional status upon admission, changes in patient status as of discharge, the effect of shorter lengths of stay on discharge destination, and the post-discharge experience.
- Measurements for quality of care should be studied to develop meaningful outcome measures. Specifically, the relationship of outcomes of medical care to the process of deliverying care and the structural characteristics of providers must be examined.
- AARP supports legislation that would allocate a fraction of the Medicare Part A Trust Fund for research into medical practice variations. For the past several years, researchers have been tracking variations in the use of medical care and have begun to discover "systematic and persistent" variations in the standardized use rates for common surgical procedures as well as other services. AARP recognizes the need for greater information about clinical outcomes and statistical norms based on average performance.

III. Strengthening consumer involvement in the Medicare program

AARP believes consumer involvement is an important factor in the development of the Medicare program. The Association is proud and enthusiastic about the beginning that has been made with consumer representation on the boards of directors of twelve PROs, as well as the Board of Directors of the American Medical Peer Review Association. But consumer involvement is important in all aspects of the Medicare program; it is the foundation upon which public support is based. The Association recognizes and supports Senator Bradley's legislation to require that all Medicare home health and skilled nursing home rules be subject to the Administrative Procedures Act (APA). AARP believes that consumer involvement in the Medicare program must be statutorily assured by making all Medicare rules subject to the Administrative Procedures Act. Consumers cannot fulfill their responsibility to Medicare if the policies, rules, and regulations governing Medicare can be made in secret and transmitted to Medicare's agents - carriers and fiscal intermediaries - without consumers' knowledge and ability to review and comment. Requiring HCFA to publish Medicare rules for public review and comment provides beneficiaries with the opportunity to influence the program before decisions about it are implemented. The publication, review and comment requirements of the APA will help keep HCFA from using nonstatutory or nonregulatory rules -- such as "technical denials" -- as a basis for denying Medicare benefits to beneficiaries who need them. Elliot Richardson, when he was Secretary of Health, Education and Welfare, made a voluntary commitment to subject Medicare to the APA. This Administration has abandoned that commitment. It is time to revitalize that commitment by mandating that Medicare comply with the APA.

CONCLUSION

Thank you again, Mr. Chairman, for your leadership in the cause of maintaining quality care under the Medicare program. My Association's interest in this area is not a selfish interest, an interest just in ourselves. We believe a simple truth binds the generations together in the quest for quality health care. That simple truth is this: The quality, or lack of it, of care under Medicare is ultimately indicative of the standard of care for most everyone else in our country. For Medicare is the flagship of the American health care system -- where it leads others follow. The issues of concern to Medicare beneficiaries today will be the issues of concern to all health care consumers tomorrow.

Senator DURENBERGER. Dr. Moncrief, would it surprise you that the American Medical Association's DRG monitoring project would turn up approximately 66 percent of the doctors responding saying that quality had deteriorated—that they would say that—under the PPS system?

Dr. MONCRIEF. I think that what surprises me is that there are only less than 500 answers.

Dr. ROGERS. It disappointed us, too, I might add.

Dr. MONCRIEF. I think that the people that answer are the ones that have got problems or perceive problems. And it is not unusual and it doesn't surprise me that that small cohort—66 percent—had perceived quality problems.

Senator DURENBERGER. Your statement indicates, and I will just quote it in the appropriate part, and I mentioned it earlier in the day:

> It should be also noted that of the number of sanctionable cases which all reflect a significant risk to the patient's well-being and in some instances death that a minority of these sanction cases are related to premature discharge. Most, however, are related to the inability of some hospitals and physicians to provide care of a quality that meets professionally recognized medical standards.

Now, that is in California; and that is a strong statement. How do you come to that conclusion?

Dr. MONCRIEF. In reviewing the records and reviewing the charts, it is not that the patient was discharged prematurely or inappropriately. It is the fact that the physician didn't use good clinical judgment in managing the patient.

Senator DURENBERGER. That is possible, is it?

Dr. MONCRIEF. Sir?

Senator DURENBERGER. It is possible that a physician can not use good clinical judgment in a particular case?

Dr. MONCRIEF. Yes, sir.

Senator DURENBERGER. And it is also possible that a hospital can not use good medical judgment in certain cases. Is that right?

Dr. MONCRIEF. True.

Senator DURENBERGER. It is probably also true that in America the issue that was raised here earlier in response to Senator Chafee's questioning, the issue of poor quality medical care, still exists. I mean, because we have access to these exotic machines and we can keep people alive forever, the presumption is that, across this country, we have always had high quality medical care; but that isn't necessarily true, is it?

Dr. MONCRIEF. No, sir; but I would correct you, sir. I think that we do have a high quality of care across the country; and if you look at the numbers from California that of 1.2 million discharges, we have identified only 110 cases out of those 1.2 million discharges that we felt warranted an initial letter of sanction. That is, the quality was such that that physician or institution should be withdrawn from the Medicare Program.

Senator DURENBERGER. Maybe I should have said "perfect" or something like that. How do you pronounce the word "nosocomial"?

Dr. MONCRIEF. "Nosocomial" are infections that are acquired in the hospital.

Senator DURENBERGER. All right. I have a little publication here entitled "Medical Benefits to the Medical Economic Digest," May 15, 1986. I don't know who puts it out, but it says here: "Estimates reveal that 1.8 million patients have prolonged hospitals stays as a result of nosocomial infection," meaning you can get sick in the hospital. Right?

Dr. MONCRIEF. Yes, sir; no question about that.

Senator DURENBERGER. Is that high-quality medical care?

Dr. MONCRIEF. I think that what we are looking at, particularly with the Medicare beneficiary, we are looking at not infrequently a patient whose immune system is compromised, either age, inappropriate diet, malignant disease—one thing or another. And that patient, put in a hospital environment, and in spite of nearly every institution having extremely rigorous methodology to prevent the spread of infection from one patient to another, it does happen. And in the elderly patient who is immunocompromised, or who is weakened by these infections, they do occur.

Senator DURENBERGER. Let me ask this of all of you who have first-hand observation. I am assuming it is the doctors, but if Louise and Andy want to jump in, that is fine, too. Assuming that nobody is perfect and assuming that 1.8 million people do contract some kind of an infection in their hospital stays—some of them even die from hospitals—assuming a lot of the evidence that seems to be out there about unnecessary testing performed on people, unnecessary procedures, unnecessary hospitalization, and so forth—there seems to be a great deal of that evidence out there—the question now that I am asking and I think, in part, this hearing is asking is:

Does the prospective payment system itself with adequate peer review necessarily make this situation worse? In other words, does it make a physician a poorer professional? Does it make the hospital of necessity a poorer professional provider? Or does it have in it, if it is properly operated, just the opposite effect—that it can improve the quality of physician care? It can improve the quality of hospital care by bringing more specialization to bear on particular cases, if again it is properly done?

Dr. ROGERS. Mr. Chairman, I would say from the AMA point of view that, if the system were perfect, yes; I think it would improve it. I think there is no question about that. Our concern, of course, is that our physicians—66 percent of them—do not consider the system perfect at this time. They consider that, in fact, their patients are being discharged too early, given all the problems of the patient, given all the problems of access to postdischarge care, given all the problems that are attendant with the care of this group of people who require far more care than the average under-65 patient.

Senator DURENBERGER. Dr. Rogers, how many of those doctors do you think just don't want to worry about that patient once they go home? You know, it is kind of comfortable to make sure they stay there in the hospital until they are perfectly well; and they go home and you can forget about them until the next time they are ill. They don't want to go to the effort of tracking them to a nursing home or getting involved in home health benefits or getting involved in calling them periodically, saying are you all right and so forth. How much of that might be attributed to——

Dr. **Rogers**. Mr. Chairman, I think most physicians across the country would follow up on their seriously ill patients who have been discharged from the hospital, by either a visit to them, or a visit in the office, or a visit to the nursing home, or a telephone call. I think, without exception, that is the goal we seek, and I think most of our physicians would achieve that goal.

Senator **Durenberger**. And they would have done that before PPS?

Dr. **Rogers**. Yes.

Senator **Durenberger**. And they are doing it now?

Dr. **Rogers**. Yes.

Senator **Durenberger**. And so, they are not complaining about having to do that?

Dr. **Rogers**. No. I think the only difference might be that, if you are able to keep your patient for a protracted period of time—as was done, 2 days longer before PPS—that would save you 2 days of calling the patient, if you will. It will perhaps make that first office visit a little further out. The patient will be in a better state of health, more able to care for himself or herself on leaving the hospital, so that the first office visit or home visit or phone call would be a little later. And so, I think it would present a little smaller burden for that physician.

Senator **Durenberger**. All right. Dr. Moncrief.

Dr. **Moncrief**. I think foremost the physician must remain the patient's advocate; and there are all sorts of pressures on the practicing physician to conform to corporate policy or hospital maximized reimbursement or whatever it is. But I think every physician has the responsibility to fight that problem if he thinks it is in his patient's best interests to stay in the hospital. And I think we see this time and again: in California, a physician's bowing to institutional pressure to get the patient out early.

Senator **Durenberger**. We have to bring all of this to a close, but this is extremely interesting and I am glad so many people have stayed to learn from it. Among the various alternative approaches, there is no preferred solution to this problem, I don't think, one over the other, though some of the questions that were asked here today might have implied that maybe if we got some kind of a capitated system or a continuum of care, that might solve the problem without attending to the data base, the information base, adequate peer review.

Does anyone here disagree with the fact that we need to do all of the above? That is, we need to have better information. We need to do more adequate peer review. We need to keep, in effect, the medical peers involved in the review process. And we need to continue to modify the DRG system in some way. We need to get a severity index. We need to be doing that sort of thing, and particularly as we move toward the competitive model.

So, we can't afford to say that we only have money to do peer review, and we are not going to work on enlarging the Medicare benefits. Does anyone disagree that we just don't have those choices? We have to move on all of these.

Dr. **Rogers**. Mr. Chairman, I think that the point made by Mr. Webber a little earlier about PRO's is a good point, however, when we ask the PRO to do bigger and greater things and don't give them a nickel more. And I think that this is putting an impossible task on the PRO. We are looking for data. Everybody here today has asked for more and better data. PRO's certainly ought to be a good source of this. They can't provide it to us if we don't give them the funds, the resources, to provide us with that information.

Senator **Durenberger**. Let me ask Andy and Dr. Moncrief the question that I asked of Bill Roper. The head of HCFA is telling us that the peer review organizations in the United States of America today don't have the capacity to undertake all of the things that we—in the larger sense, society and those of us who are responsible for the health policy for the elderly and disabled—would like them to take on. And I think that was directly stated in the testimony in response to my question, that he looks out at the field and they have 16 of 31 PRO's that they have sort of put on hold—hey have rejected three of them entirely—and so forth.

There seems to be a professional concern on the part of HCFA that the organization or the management, or whatever it is, capability of PRO's in America is not up, as of right now, to the task of undertaking all of the kinds of quality-related review over the next couple of years that we would like them to undertake. How do you react to that?

Mr. **Webber**. I think there is no question that there is still some instability in the program. It is a program in its infancy. Certainly, as I commented in my oral remarks, I think some of it has to be pointed back at HCFA in terms of the uneven administration, the very frequent instructions, the prescriptiveness.

I think the larger issue here is certainly the issue of funding. Given the Federal deficits, I think it is clear that the administration does not want to go beyond the dollars set in the PRO statute to fund the program. And so, their enthusiasm for PRO expansion is certainly dampened by their position that we do not want to expend any more dollars for this program. I think with the additional resources, and with better management of this program, and given some patience by the administration, that certainly PRO's could take on expanded activities. And if we are truly concerned about quality of care, then we have got to start to look at patient outcomes beyond just hospital-based episodes.

Senator **Durenberger**. Where do we get the evidence for how many dollars are needed? Can we describe the requirements—the peer review requirements—and have somebody come up with the dollars that are necessary? This is an endless debate. The IG, I think, was going to say that there is money around. HCFA says there isn't enough money, or they won't spend it. And you say the PRO's are not being paid enough.

How in the world do we answer that question? How much do we need to do what?

Mr. **Webber**. First, it depends on the design of the program and how comprehensive you want it. If you want to take a 5-percent sample of cases, obviously it is going to cost less than if you want a full sample or if you want to fund a full data system that looks beyond hospital-based care. It depends very much on the design of the effort.

Senator **Durenberger**. Then, what you are suggesting we have to do is break out our objectives. If we want them to do research, then here is how much the research costs. If you want us to get at the issue of quality precisely, we can do it for you in this State with a 5-percent sample, and in this State going after these 10 percent of the providers, or whatever——

Mr. **Webber**. I think the biggest frustration that the PRO community has right now is this absence of a PRO purpose statement. What truly are we here for? And depending on who you talk to in this town, whether it is OMB or whether it is HCFA or whether it is the AARP and the beneficiary community or whether it is the inspector general, you get a very different answer. Is it cost containment? Is it medical prosecution? Are we consumer guides? Are we quality assurance protectors? And are we true peer reviewers back in our physician communities?

We need to answer that question before we can establish what the funding provisions should be and how we are going to evaluate PRO performance. I don't think that has happened. I don't think we have developed consensus around that issue.

Senator **Durenberger**. I would have to agree with you. I have no reason to disagree. We really haven't focused on what it is we want.

Dr. **Moncrief**. Senator, if the PRO's don't have the capacity, and if capacity means they lack the resources, the answer is "Yes." I think in every PRO there is the incentive and there is the management skill and there is the desire to prove or show that the Medicare beneficiary is getting quality care; but as Andy has just spoken so eloquently to, most PRO's don't know from week to week what their primary objective is. And I think this was thoroughly exposed in the self-evaluation program.

Senator **Durenberger**. I don't want to belabor this, but didn't we create some sort of a monster PRO that is supposed to overlook——

Mr. **Webber**. A super PRO—a super PRO.

Senator **Durenberger**. How do you do that?

Dr. **Moncrief**. Well, not only that, but I see in Mr. Kusserow's prepared statement, that he is going to repeat what the super PRO has done: on a series of 240 hospitals, 30 admissions and 30 clinical records randomly selected from 240 randomly selected hospitals, and I don't know. I do know in California there is not a month or a week that goes by that we don't have some type of an auditor checking on this: on what we are doing and how we are doing it and what the results are.

Senator **Durenberger**. Yes.

Dr. **Moncrief**. And each auditor reviews this with a different objective.

Mr. **Webber**. And Mr. Chairman, remember that the super PRO is only looking at how PRO's review each individual case, whether they made the right decision. And there is a lot of PRO performance that has more of a subtle impact out there in the community that hasn't been measured at all: the sentinel impact of preadmission certification, the physician that retires under PRO review, rather than gets marked down as an individual sanction, the hospital that establishes a quality assurance program because they know the PRO is going to start the institute quality screens.

This kind of intangible impact of the PRO program, I don't think, is measured at all by super PRO or any of HCFA's evaluations to date.

Senator **Durenberger**. All right. Lady and gentlemen, thank you very much. I am sorry to interrupt your lunch, but not as sorry as we are for Jack Owen, Margaret Cushman, and Paul Willging, who have been even more patient than everybody else here today. [Laughter.]

All of your statements have been made part of the record. The quicker you get up here, the quicker you get to read them. We will proceed with Mr. Owen who knows how to be brief. You are down to 4 minutes now, but the important thing is that your statements are in the record. You know that you can elaborate on them. I presume that you have been here for most of what I consider to be a very good and comprehensive hearing today. So, to the degree that you would like to elaborate, since you are the provider groups that are involved in this sort of process, and if you would like to elaborate on your statements in light of some of the questions that have been asked here today, please feel free to do so. We will start with Jack Owen.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. **Owen**. Thank you, Mr. Chairman. I will not read my statement. I am here really to support Senate bill 2331. I would just like to make a couple of comments in regards to what has occurred earlier in this hearing and then a couple of comments quickly on the bill itself that I think would be helpful as you act on the bill.

First, there has been a real allegation that hospitals have overreacted to this whole prospective pricing incentive program. And yet, as you listen to the people both from the PRO's and from HCFA and from HHS, from our statistics there is no evidence that we have uncovered that indicates that there is a wholesale deterioration of quality of service as furnished to the Medicare beneficiary.

Sure, there are some things that have happened, and I would be less than honest if I sat here and said there wasn't one hospital or one physician in this country that didn't make a mistake. Medicine is an art; it is not a science; and there is room for that kind of mistake. But there has been no wholesale evidence of any kind of deterioration of quality.

HHS and the inspector general have found a scant 1.4 percent of the cases targeted for further review that were identified for any further study beyond that. So, we think that overall the hospitals and physicians are doing a pretty good job. The length of stay certainly has been decreasing, and that has been of concern to almost any patient who has been put in the hospital. I might just add, however, Mr. Chairman, that the rate has slowed. We see that slowing now for the past year.

In the last quarter of 1985 and this first quarter of 1986, we are actually seeing an increase in the length of stay in the DRG's. And this is understandable because you reach a point where you have squeezed everything you can out; and if you are going to admit somebody for a diagnosis, there is going to be a certain number of days. But we are actually seeing a small percentage in this last quarter of increases, and that means not only a longer length of stay, but it has some ramifications also as far as dollars are concerned in taking care of patients.

But the whole purpose of the prospective pricing system, as you well know, and you are as much responsible for this program as almost anybody here in the Senate, was to gain efficiency and use less resources in taking care of people as well as we could. I think we have done that.

Beneficiary complaints, you have heard about; they are perceived and they are real. And I think most of the problem is that the current benefit policies that were developed were really developed for in-patients. In 1965, when we went into this program, we were only thinking about in-patients; and we weren't really thinking about the other kind of care that is necessary when you discharge a patient as soon as we must now. Acute care was the major source of care; now we see all kinds of outpatient care being prescribed and given; and of course, with that comes that perception that people are not being taken care of as well as they were before.

I would just make a couple of comments on the bill itself on a couple of issues in that bill that we would hope be picked up or changed a little bit in some cases.

First, the refinements of the DRG's, the resources required by patients, the severity of illnesses—we think that is a must. It has got to be done, especially as you move toward a national rate. I have talked to you a number of times about this; and the question really is: Is the hospital efficient or is it nonefficient? Or is it because the patient needs more care, and that is why more resources are being used?

So, we have got to move in some direction to look at the price of severity and the cost of it.

We are certainly in favor of enhancing the beneficiary understanding. We agree that something must be done to let them know, to get the education much earlier; and we have worked with AARP—the senior citizens group—and the Committee on Aging. And the only thing I would say is that when we highlight what patients must do in order to get appeals, we must also highlight the limitations of Medicare coverage because hospitals do not establish the limitations. These limitations are established by the Government.

Overall, the access, the discharge planning, we are very much in favor of these approaches. We think there are enough studies that have been done. A lot of things are already studied to death, and we think that in many cases you should move ahead instead of just calling for another study when these studies are already there. We recommend that this bill be approved and passed, and we commend you and Senator Heinz and the Senate for focusing on quality because that is what we are concerned with as well.

And I would be happy to answer any questions on my testimony.

Senator **Durenberger**. Thank you. Ms. Cushman?

[The prepared written statement of Mr. Owen follows:]

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES SENATE
ON
THE QUALITY OF CARE UNDER MEDICARE

June 3, 1986

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA) and Director of the Washington Office. On behalf of the 5,600 institutional and 40,000 personal members of the Association, I am pleased to have this opportunity to discuss the quality of hospital care furnished to Medicare beneficiaries.

In a few short years, we have witnessed monumental changes in the way medical services are delivered in this country. Most of these changes have a common goal: to reduce the amount of inpatient hospital services and to increase the proportion of services furnished in less intensive and less expensive alternative sites so that fewer national resources are devoted to medical care.

These changes have not occurred by chance. They have been the result of deliberate policies of the Congress and the Department of Health and Human Services, and by other purchasers of health services. In 1982 and 1983 Congress took decisive steps. First it created the Peer Review Organization program to control the volume and quality of services furnished to Medicare beneficiaries. Shortly afterward Congress revolutionized hospital payment by creating the prospective payment system (PPS), which attempts to achieve, through the right mix of incentives, the specific goals that had seemed unachievable through earlier attempts to control costs and utilization by direct regulation.

Hospitals have responded. Hospitals are providing services more efficiently. Changes in staffing patterns, continued reductions in length of stay, and increased use of outpatient services have kept hospital inflation under 6 percent. In addition, reflecting the dramatic changes that have taken place in health care delivery over the past three years, particularly the increased reliance on outpatient services, hospital admissions have plunged.

Despite these evidently positive results, a great deal of public attention has been directed in recent months to the question of whether the quality of hospital care has deteriorated under Medicare prospective pricing. It has been alleged that hospitals have overreacted to PPS incentives by discharging patients when they still need hospital care. S.2331, recently introduced by Senator Heinz, is specifically addressed to the problems perceived to be created by PPS's efficiency goals.

The AHA shares the Senator's concern that quality not be compromised on the way to more efficient utilization of resources. That is part of the reason the AHA acknowledged the need for external monitoring of hospital services in its own policy statement on prospective pricing, and revised its formal policy on the PSRO program. But the AHA has seen no evidence of wholesale deterioration in the quality of services furnished to Medicare beneficiaries. The incidents that have spawned this debate have been deplorable, and such incidents need to be dealt with aggressively, but they have been isolated cases from which wide-scale abuse and generalizations about poor quality hospital care cannot be inferred.

The PROs, which have been reviewing nearly half of all Medicare admissions--mostly retrospectively--and which were charged by Congress to assess the adequacy of services furnished to Medicare beneficiaries, have uncovered very few cases of "premature discharge" or inadequate hospital care. In order to detect premature discharges, PROs have been required to review every case of readmission within seven days of hospitalization. They have found few problems. In its recent review of PRO activity in this area, the Department of Health and Human Services' (HHS) Office of Inspector General (IG) found evidence of early discharge in barely more than 1 percent of the readmissions targeted for review, few of which implicated the hospital. At least 97 percent of these discharges came about at the express direction of the patient or the patient's physician.

There is no question that the average length of hospital stays has been decreasing, a trend that began before implementation of PPS. In mid-1983, before PPS took effect, the average length of stay in hospitals began to decline for Medicare patients, and even more dramatically for patients under 65. As hospitals began to economize and to furnish services more efficiently, length of stay fell more precipitously, but this trend appears to have bottomed out. The rate of decrease slowed steadily throughout 1985, and in the last quarter of 1985 the average length of stay for elderly patients actually increased slightly.

Yet, the wide perception that our high-quality system of medical care is deteriorating persists. The beneficiary reports that have fueled the debate on deteriorating quality reflect two distinct types of complaints--there are those who believe that they have received inadequate acute hospital care and those who have been unable to obtain needed post-hospital care. Underlying both types is a great deal of confusion and frustration among beneficiaries over the unrealized expectation that the Medicare program will cover all their health care needs, something Medicare was not designed to do and that current changes imposed by the Medicare program render increasingly unlikely.

Medicare benefit design and payment policies do not reflect the complexity and diversity either of patient needs or of the providers available to meet these needs in today's environment. Medicare benefit policies were developed over the past 20 years from a system of cost-based payment and an approach to the practice of medicine that was oriented toward acute inpatient hospital care. In a few short years, we have moved dramatically away from both. Hospitals are still the single most expensive component of overall medical expenditures, but the emphasis is moving away from hospital treatment.

This push to limit hospitalization is taking place rapidly under strong pressure by Medicare and other payers. For the patient, who has not necessarily asked for things to be done differently, we may have come too far too fast. Many payers, including Medicare, are making decisions about treatment site based on the average patient, without taking sufficient care to accommodate the unique needs of some patients. The criteria for making level-of-care decisions are not well developed, and need to be refined. But it can be done. In one state, the PRO declared that all hernia repairs under Medicare would have to be done on an outpatient basis, which physicians in the state believed to be unsafe for some. A working party of hospital medical staffs formed over the issue and worked with the PRO to develop a set of criteria for distinguishing appropriate from inappropriate admissions for hernia repair. But this is the exception. Most medical review criteria have not been tested to assure their validity or reliability for the Medicare-eligible population.

The ability to substitute alternative settings for hospital care as a result of technological advances requires a reassessment of the Medicare benefit, including restrictions--e.g., the three-day prior hospitalization rule for access to skilled nursing (SNF) services--on access to non-hospital care. For example, many patients now being treated surgically as outpatients may need further care at a skilled nursing level, but would be ineligible for Medicare payment of skilled nursing services because of the three-day prior hospitalization rule. Others may begin home treatment though a home health agency but find themselves unable to sustain home care and unable to get into a SNF because Medicare covers SNF care only as an extension of inpatient hospital services.

Appropriate changes in the Medicare benefit could promote the use of alternatives to hospitalization at the same-time they could enhance the availability of post-acute care. Congress should consider repealing the budget neutrality provision that has impeded the Secretary of HHS from taking advantage of the authority to waive the three-day prior hospitalization requirement in certain circumstances. At the same time, Medicare needs to eliminate arbitrary barriers to the provision of needed services by hospitals. Where post-hospital services are needed but appropriate facilities are not available, hospitals should be able to provide the services and be paid for them at the appropriate level.

One effect of PPS has been to call attention to the existence of many different levels of medical need both within and between the current categories of "hospital," "skilled nursing," and "home health" care. This highlights the need to establish medical review criteria differentiating among all levels of care, to identify providers capable of delivering each level of care, and to assure continuity of care across all levels.

The AHA believes that the perceptions of deteriorating quality are rooted in the changing way medical care is delivered. This is especially true when the change carries with it some element of inconvenience to the beneficiary or restriction on access to services that had not existed before when all services were furnished within the hospital and all needed hospital care was paid for. These changes will mean more efficient delivery of services and may be beneficial to the patient as long as the alternatives to inpatient hospitalization are available and accessible.

This is not to say that nothing can be done to improve the quality of services furnished to Medicare patients. The Medicare Quality Protection Act of 1986, introduced last month as S.2331, takes some important steps toward addressing the complex issues surrounding quality of Medicare services under PPS. This bill would take three broad approaches to addressing the quality of care under Medicare:

- Modify PPS to adjust payments for the different types of patients treated by different hospitals, which would help minimize the risk to beneficiaries of premature discharge without jeopardizing the positive incentives for cost control established through PPS;

- Expand the availability of post-acute care and the capability of hospitals to place patients in an appropriate facility or to furnish needed follow-up care; and

- Improve the quality assurance role of the PROs.

Although we would recommend some changes to the bill, the AHA agrees that all three approaches will contribute to improving the quality of Medicare services. Following are some comments on major provisions of the bill that we would like the Committee to consider.

QUALITY IN ACUTE HOSPITAL SETTINGS

Refinements to PPS

Because PPS establishes a price per case according to diagnosis and procedure, providers are given incentives to produce and use hospital services efficiently. Theoretically, hospitals that do well under the system are those that can lower costs and operate more efficiently. Efficiency can be improved by increasing productivity, thereby decreasing the costs of services, or by increasing clinical efficiency--shortening average length of stay and decreasing the use of marginal services. This was the intended result of PPS. If this intended result is to be achieved, the Diagnosis Related Group (DRG) system must accurately reflect the costs of treating Medicare patients. The AHA has expended considerable energy in an effort to call attention to the limitations of DRGs and to develop methods of setting prices that will not penalize hospitals for treating severely ill patients.

Because HCFA has never been able to demonstrate that DRGs do, in fact, adequately reflect the resources required by patients for the treatment of their illnesses and injuries, the question is now raised whether reductions in cost that have been achieved by hospitals in the past two years are the result of increased efficiency or of a reduction in the provision of needed services.

The proposed legislation calls for HHS to develop and submit a legislative proposal to refine PPS to assure that prices approximate the cost of efficiently provided and medically necessary care, and to account for severity of illness. We would wholeheartedly support an attempt to refine the DRG classification system so that fair payments are made for the treatment of well-defined and homogeneous groups of patients. The efficiency goal of PPS can be appropriately met only when the assumptions underlying the incentive structure--that payments will be based on averages defining uniform groups of patients--are met. The proposal to require the Secretary to study DRGs is a step in the right direction, but it does not go far enough.

In developing its proposal, HHS should be required to demonstrate whether differences in average costs among hospitals stem from differences in efficiency, in which case they are not a cause for concern, or from differences in patient needs. If HHS finds that cost differences are not due to differences in efficiency but to the treatment of different kinds of patients, a further step should be taken.

The AHA encourages exploration of ways to account for severity of illness in the DRG classifications, but given the practical limitations of existing severity indicators, AHA recommends that Congress give serious consideration to alternative methods for more accurately pricing services. The AHA believes that its DRG-specific price blending proposal is the best and most immediately accessible solution to the problem of accounting for severity. The AHA is currently examining other solutions to compensate for the defects of DRGs and to create positive incentives for the treatment of patients with unusually high medical needs (e.g., outlier price adjustments) and encourages Congress to do the same.

The proposed legislation sets a January 1, 1988 deadline for the HHS report. This should be moved up to 1987. On January 1, 1988, fully two-thirds of all hospitals will be paid at uniform national rates, the remaining third to follow within six months. By this time the ill effects of inadequate compensation will already be keenly felt. Because there are feasible alternatives such as the AHA proposal that could be implemented quickly, and because of the urgency of the problem, the earlier date is preferable.

Enhancing Beneficiary Understanding and Appeals

As noted above, one of the important causes of beneficiary complaints is wide misunderstanding by both beneficiaries and providers of the DRG-based system, the scope and limitations of Medicare coverage for hospital and post-hospital services, and the beneficiary's rights to appeal hospital and PRO coverage decisions. The legislation proposes two amendments to the Medicare statute that would increase beneficiary understanding of Medicare coverage determinations and appeals.

First, it would require hospitals to distribute notices informing beneficiaries about their rights to hospital and post-hospital services. An existing provision in the regulations governing the PRO program led to the development and distribution of a similar "Message from Medicare" that hospitals were instructed to distribute to all Medicare patients earlier this year. AHA agrees that the inability of beneficiaries to obtain clear, coherent information from Medicare is a significant problem and has cooperated with HCFA and congressional staff to make information available.

In describing the beneficiary's rights, the Secretary should also be required to highlight the limitations of Medicare coverage imposed by the Medicare statute for hospital and post-hospital extended care services, as well as administrative limitations imposed by the Medicare program (e.g., limitations on access to acute hospital care through PRO-established acute care criteria). Hospitals, after all, do not establish such limitations; Medicare does.

To enhance beneficiary understanding of Medicare appeals, the bill would incorporate existing procedures under PPS regulations for hospitals and beneficiaries to obtain a PRO review when the hospital determines that continued in-hospital treatment is no longer necessary. The proposal would: clarify that the patient has the right to a PRO review of the hospital's determination; shorten from three working days to three calendar days the amount of time the PRO would have to perform an expedited review requested by a beneficiary who is still an inpatient; and expand to three days the time a hospital must allow before billing a beneficiary for unnecessary inpatient care.

We support the clarification of the patient's right to a Medicare coverage determination by the PRO within three calendar days. It is not in anybody's interest to prolong the wait for a definitive Medicare coverage decision on the appropriateness of the discharge, which can only be rendered by the PRO, and which, in the vast majority of cases, will agree with the determination of the attending physician and the hospital's utilization review committee. The AHA believes, however, that two days are sufficient time for the patient to arrange for post-discharge care. Expansion of the grace period to three days would be inconsistent with past practice under per-diem payment, when Medicare generally allowed one or two days to arrange post-hospital care, and with the PRO law, which allows the PRO to authorize Medicare payment for a maximum of two days for making post-discharge arrangements. It should also be made clear that the additional days spent in the hospital without patient liability are granted only for the purpose of arranging post-hospital care.

Two days should also be sufficient for the PRO to perform its review of the appropriateness of the physician's discharge order. If it is not, then changes in the organization of the PRO program are in order to allow review to be performed closer to the place where care is delivered.

In S.2331, Senator Heinz has suggested two additional statutory amendments that would greatly enhance public awareness of Medicare rules and would increase the public accountability of the Department. First, the bill would require HHS to adhere to Administrative Procedures Act requirements for public review and comment on all Medicare and Medicaid regulations. Furthermore, the bill proposes that HHS be required to publish a notice in the Federal Register whenever it issues a substantive guideline or program instruction to fiscal intermediaries, including instructions for obtaining them. The AHA encourages the adoption of both suggestions, although we would recommend extending the notice requirement to guidelines or instructions issued to PROs.

Hospital Quality Assurance

The legislation calls for HHS to study the adequacy of the Medicare conditions of participation and to report to Congress within two years on the results, deferring any changes in the current conditions that may affect the quality of hospital care until the study is completed.

AHA encourages evaluating the relationship between the conditions and the quality of hospital care. Such evaluations of existing regulations should be performed routinely, and in the case of the conditions of participation, Medicare periodically does just that to assess the "deemed status" granted to those hospitals accredited by the Joint Commission on Accreditation (JCAH). On the basis of a substantial reevaluation undertaken several years ago, Medicare concluded that major revisions were necessary. These were proposed in 1983. Public comments on the proposed revisions have been under intensive review for more than three years.

The proposed revisions to the conditions of participation are a considerable achievement in regulatory reform. Outdated structural requirements are replaced with process and outcome standards that more specifically address the quality concerns of the Medicare program. For example, these revisions in their final form contain a new quality assurance standard that would require hospitals to perform discharge planning, a function that is not currently required and that S.2331 proposes to establish as a required hospital function. These rules, once finalized, will enhance, not diminish, the Medicare program's quality oversight, and would accomplish one of the specific goals of the proposed Medicare Quality Protection Act of 1986. Impeding the publication of these rules would be self-defeating. We would strongly oppose any attempt to restrict promulgation of the proposed revisions to await a study that has, in effect, already been completed, and whose results are now waiting to be implemented.

Hospital Provision of Extended Care Services

The bill would require HHS to study the treatment of "administratively necessary days" (ANDs), days spent in the hospital awaiting placement in a skilled nursing facility (SNF). The study would determine the extent to which current prices include and adequately reflect the actual costs of providing these services and whether additional payments should be made for them. The bill calls for any additional hospital payments to be "budget neutral."

The AHA favors the elimination of barriers to the hospital provision of needed post-acute services when SNF placement is not possible, and would support payment to the hospital at the SNF rate for the additional days of non-acute service. In testimony before the House of Representatives on this legislation, Senator Heinz himself agreed that the SNF rate of payment would be reasonable and that adherence to budget neutrality in this case would be unfair. As a result of the increasing scarcity of available Medicare-covered SNF services, hospitals are more often keeping patients who do not need acute care in the hospital without any additional payment by the Medicare program.

This provision should be expanded to require the Department to consider ways to enhance the ability of hospitals to furnish post-acute services while ensuring payment for any additional services hospitals may provide.

However, the AHA would oppose attempts to make additional payments "budget neutral." Over the past two years, inflation on the one hand and the inadequate Medicare price increases on the other have confronted hospitals with a real decline in payment levels of nearly 8 percent. Additional amounts for ANDs cannot be wrung out of existing payments. The provisions should say simply that payments will be made under Title XVIII and will be separate from per-case and any outlier payments.

ACCESS TO APPROPRIATE POST-ACUTE CARE

Required Discharge Planning in Hospitals

The proposed legislation would make discharge planning a required hospital function. It would further require the Secretary to develop guidelines and standards for discharge planning, and specifies how the function should be structured.

The AHA has long encouraged the development of effective discharge planning programs. Discharge planning can improve the quality of patient care planning, increase the efficiency of the provision of hospital services, round-out the continuum of care, and assure appropriate discharge placement. As noted above, proposed revisions to the Medicare Conditions of Participation, which the AHA supports, include a required discharge planning function for hospitals. If these regulations were published, the legislative amendment would not be necessary. However, the AHA considers discharge planning essential for maintaining high-quality hospital care, and would not oppose a legislative requirement that such services be provided.

Waiver of Liability

AHA understands the reasons for maintaining a measure of security under the waiver of liability provisions for home health agencies (HHAs) and skilled nursing facilities (SNFs). The waiver of liability provisions in Sec. 1879 of the Social Security Act protect beneficiaries and providers from financial liability when it is determined after the fact that services rendered would not be covered by Medicare. The proposed provisions would prevent the implementation for HHAs and SNFs of new administrative procedures that have been adopted for determining whether hospitals should be paid under the waiver. Such procedures are expected to erode the protections intended by the legislation.

Hospitals, too, currently operate under a great deal of uncertainty regarding Medicare coverage and payment for services that the hospital has already, in good faith, provided. If Medicare coverage criteria were clear cut, the waiver would serve little purpose. But the coverage issues decided by the PROs are anything but clear cut, as evidenced by the wide discrepancies between what the "SuperPRO" (an organization contracted to review the accuracy of PRO decisions) and the PROs believe appropriate. When this uncertainty is coupled with severely diminished access for hospitals to the waiver of liability, hospitals bear a significant financial risk for erring on the side of safety, for choosing to admit a patient when coverage is in doubt. If Congress wishes to change incentives to add further protections for beneficiaries, it should reinstate the use of the favorable presumption to preserve a safety margin for hospital errors in coverage determinations as well.

PRO Appeals

The AHA enthusiastically supports Sec. 207, which would allow providers to represent beneficiaries in their appeals of Medicare coverage decisions, and would allow providers and practitioners to appeal administrative or technical denials and any other denials of Part A claims. We hope it would be clarified to indicate that providers and practitioners should have access to appeal any payment determination beyond the reconsideration by the PRO.

Reports on Quality Assurance

In expanding the scope of HHS' annual reports on PPS to include information on the quality and accessibility of post-hospital services, the AHA suggests thatSec. 208 be amended in two ways. First, the report should require an assessment of the role hospitals should play in meeting the needs of beneficiaries for post-acute care. Second, in its review of the impact of PPS on the quality of patient care, HCFA should be required to investigate broadly the impact of PRO review and coverage policies on the quality of services available to Medicare beneficiaries. For example, PRO contracts have placed a great deal of emphasis on treating certain medical conditions on an outpatient basis; at the same time, HCFA has adopted a policy not to allow PROs to consider social factors like the availability of family support at home or the distance of the patient's home from the facility in making admission decisions.

The Prospective Payment Assessment Commission (ProPAC), created by Congress to oversee PPS, has conducted a preliminary investigation of the impact of PPS on the quality of Medicare services. ProPAC found that the drop in length of stay occurred in the provision of routine care, not the care provided to the most seriously ill patients, and the level of ancillary services has not changed substantially under PPS. ProPAC concludes that the problem of earlier discharge may be more a problem of the availability of Medicare coverage for post-discharge care than the inadequacy of hospital services provided. Moreover, despite marked increases in hospital reported discharges to home health or skilled nursing facilities, Medicare coverage of home health and SNF services has not increased commensurately. Finally, ProPAC suggests that the impact of Medicare-enforced shifts to outpatient services should be analyzed for their impact on the quality of care.

IMPROVED QUALITY REVIEW BY PROs

Congress created the PROs to provide both utilization and quality control for Medicare services. Although the first PRO contracts focused heavily on utilization control--reductions in hospital admission--HCFA has revised the PRO review plan to place more emphasis on the review of hospital discharge over the next two years.

Congress recently enhanced the PROs' ability to address quality problems through payment denials, but may have inadvertently made it more difficult for PROs to devote appropriate energy to quality review. The Consolidated Omnibus Budget Reconciliation Act of 1986 significantly adds to the PRO workload, requiring HMO and some outpatient surgery review beginning in 1987. At the same time, budget reductions under Gramm-Rudman will sharply reduce the amount of funds available for PRO review.

The AHA has often stated its view that the PROs can be an effective means of addressing quality problems, but only if:

- they can develop reliable criteria by which the quality and necessity of services can be effectively screened and objectively judged;
- they are given the flexibility to focus on providers with demonstrated patterns of inapproporiate behavior;
- they are sufficiently funded to pursue educational interventions, and if these fail to produce more desirable behavior, appropriate sanctions; and
- PRO decisions are subject to review and appeal by some entity other than the PRO.

The AHA is very encouraged by provisions in the proposed legislation that would increase PRO accountability by enhancing the ability of beneficiaries, practitioners, and providers to appeal PRO decisions. Other provisions, however, would not necessarily be taking the PRO program in the right direction.

Hospital Data Submission

Sec. 301(a), which would amend Sec. 1153 of the Social Security Act to require hospitals to supply data directly to PROs to expedite the review process, is unnecessary and would be wasteful and counterproductive. There is no need for a separate data-collection cycle for use by PROs because the information they need to initiate review can be obtained through the billing process. Current problems in the timing of PRO review are generally the result of poor data coordination between the PROs and the fiscal intermediaries. This provision should be revised to bind the fiscal intermediaries to more timely submission of data to the PROs.

Readmission Review

During the first two years under PRO review, PROs have been required to review all cases of readmission within seven days of a prior hospitalization.

According the the HHS Office of Inspector General, which recently investigated this review activity, only 1.4 percent of those cases reviewed were found worthy of further study. Only 60 percent of these--less than 1 percent of readmissions reviewed--reflected potential quality concerns. Researchers looking into Medicare readmissions have found that they are often the result of chronic illness among the Medicare population, and often reflect the unmet need for supporting social services outside the hospital. For example, surgery patients were found less likely to be readmitted, while the disabled, Medicaid-eligible, and rural beneficiaries are more likely to be readmitted.

Sec. 301(b) would require PROs to review readmissions within 31 days. This is far too long a period to capture true cases of "early readmission." While existing evidence strongly suggests a need for discharge planning, it does not suggest that readmissions are linked to widespread quality problems. It is unlikely that casting a broader net than that proposed for the next PRO contract period--PROs will review all readmissions within 15 days of hospitalization--will do anything more than highlight the need for Medicare to address the special problems of its chronically ill beneficiaries. If readmission review is to be required, readmissions within 15 days would adequately capture cases of "early" readmission.

Data Disclosure by PROs

Sec. 305 would expand the list of organizations with access to information held by PROs on providers or practitioners beyond the state and federal agencies currently entitled to PRO information under Sec. 1160 of the PRO statute. The Secretary would appear to have broad discretion in determining who meets the definition of "State ombudsmen and State protection and advocacy officials" who would be eligible under the proposed legislation to receive confidential PRO information. Given the uncertainty as to precisely who would be entitled to receive this information, we would oppose this provision since it does not offer adequate confidentiality protections. PROs are already required to share information with state licensing and public health agencies, and are free to make public their conclusions about the quality of care in any hospital as long as they do not release confidential quality information.

CONCLUSION

In closing, Mr. Chairman, the AHA wishes to commend the efforts of both of the primary sponsors of this legislation in their attempt to focus attention on the operation of Medicare PPS and its relation to quality of hospital inpatient care, as well as the availability of covered post-acute care for Medicare beneficiaries. We look forward to working with the Committee to modify certain portions of the bill so that it will lead to improvements in PPS for both Medicare beneficiaries and providers.

STATEMENT OF MARGARET J. CUSHMAN, M.S.N., R.N., EXECUTIVE VICE PRESIDENT, VISITING NURSING AND HOME CARE, WATERBURY-HARTFORD, CT; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Mr. Chairman and members of the committee, I am Margaret Cushman. I represent the National Association for Home Care. We commend you for holding this important hearing.

The implementation of the hospital prospective payment system has had a dramatic impact on home care agencies, both in terms of the acutely ill patients being discharged to home care and the numbers. There have been numerous studies cited today; there are additional ones in my written testimony to support that fact. Despite the documented increase in the demand for home care services created by the DRG system, the Health Care Financing Administration has sought to curtail the Medicare home care benefit.

They have done this citing the increase in the need for home care as the very reason for curtailing costs. The new cost-limit regulations published last year disallow aggregation. Without being able to aggregate costs, the agencies' management flexibility is severely limited. As a result, high technology and other costly services are being limited or not offered at all, and certain types of patients, particularly in rural areas, may not have access to care.

Further, per publication of the new cost limits last Friday, the Health Care Financing Administration is using 1983 data for determining the July 1, 1986, cost limits to be calculated at 115 percent of the mean or visit costs.

That poses a serious problem because the 1983 data did not contain the information related to the impact of DRG's and the implementation of the new forms that home health agencies are now required to use. In addition, under the Gramm-Rudman-Hollings Act, HCFA's intermediaries have been instructed to withhold 1 percent of claims and provide interim payments for home care agencies. This is particularly devastating to home health agencies as they are cost-reimbursed and have no way to recover a 1-percent loss on costs.

Third, there are restrictive interpretations of the "intermittent care" requirement. "Selective billing," where fiscal intermediaries are advising home health agencies who have patients receiving payments under Medicare that they may not be eligible for Medicare coverage if additional coverage is needed and received from other sources of payment, including self-pay, is a related problem.

And finally, delays in the processing of home health agency claims are crippling agencies. There is a report of March 19, 1986, to Congress prepared by our Association called 'The Attempted Dismantling of Medicare Home Health Care Benefit." We would be pleased to make it available to you for part of the record of this hearing. It discusses, in addition to what I have talked about today, other devastating attempts to cut the home care benefits.

The Medicare Quality Protection Act of 1986, S. 2331, is legislation that will go a long way in improving the quality of care for Medicare beneficiaries and assuring that they are cared for in an appropriate setting. We are pleased that the provisions include items which facilitate appropriate transfer from hospitals to home health agencies and other settings.

We support the legislation and will assist in working toward its enactment. Particular provisions we support include requiring discharge planning as an integral part of the process in all hospitals, extending the waiver of liability coverage to so-called technical denials, particularly as it relates to homebound or intermittent care requirements, and the provision which would make the waiver of liability permanent. We agree that we need to take a closer look at examining and developing a better uniform needs assessment instrument which would help to determine Medicare coverage of home health agencies' services.

And probably the biggest problem facing home health agencies and beneficiaries today is the delay in payment and the need to speed up claims processing. In addition to S. 2331, we recommend other corrective legislation be enacted to ensure the availability and quality of home care services, including those submitted by Senator Heinz—S. 778 and S. 2494.

Senator **Durenberger**. Thank you very much. Paul?

[The prepared written statement of Ms. Cushman follows:]

Testimony of

Margaret J. Cushman, MSN, RN
Executive Vice President
Visiting Nurse And Home Care
Waterbury-Hartford, Connecticut

on behalf of the
National Association for Home Care

before the
Finance Committee
United States Senate

June 3, 1986

Mr. Chairman and Members of the Committee:

My name is Margaret Cushman. I am the Executive Vice President of Visiting Nurse And Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the Secretary of the Board of Directors for the National Association for Home Care (NAHC), and as the Chairman of NAHC's Government Affairs Committee. NAHC is the nation's largest association representing home care professionals and paraprofessionals with approximately 3,000 member organizations. On behalf of these organizations, I would like to commend you for holding this important hearing.

Impact of DRGs on the Home Health Industry

The implementation of the hospital prospective payment system has had a dramatic impact on the home care industry, both in terms of the acuity level and the number of patients needing home care after a hospital discharge. In addition to the volume of anecdotal evidence from home care providers relating that patients are being released from hospitals "quicker and sicker" since the implementation of DRGs, there have now been several studies documenting this occurence. In response to a request by Senator John Heinz, Chairman of the Senate Special Committee on Aging, the General Accounting Office (GAO) prepared a report which concluded that under the DRG system, patients were in fact being released from hospital patients to home health agencies (HHAs) had increased in over 83% of the agencies surveyed. Last year, the Eastern Washington Area Agency on Aging (EWAAA) in Spokane, Washington conducted a study on the effects of DRGs on community based agencies in Eastern Washington State. This study concluded that home health agencies are bearing the brunt of the effects of earlier discharges under the DRG system. The study found that under the DRG system, the number of reimbursable home visits rose 27% for urban home health providers, based on six month data for comparable periods during 1983 and 1984, and that professional nursing visits rose 37% in urban areas and 18% in rural areas. In response to the increased acuity of patients being seen in the home, the study found that home care providers are:

* Purchasing or planning purchases of more sophisticated equipment such as intravenous pumps and hospital beds.

* Securing training for personnel on topics ranging from the use of more sophisticated medical equipment and devices to the performance in the home of complicated nursing procedures.

* Experiencing an increase in the use of traditional nursing supplies such as skin care products, gauzes, irrigation sets, and intravenous kits.

- Experiencing an increase in the demand for the delivery of rehabilitative services, especially speech and physical therapy services.

- Experiencing an increase in the growth of staff nurses, aides, and office personnel. At one agency, the number of full-time RNs rose from 11 to 45 between June 1983 and June 1984, home health aides increased from 17 to 25 FTEs, and physical therapy staff increased from one to two members.

A study conducted by the Home Health Assembly of New Jersey documents similar results. In 1980, New Jersey became the first state to implement a prospective payment system for hospitals based on DRGs. The New Jersey study found that:

1. The DRG systen in New Jersey has increased the number of hospital referrals to home health care.

   New Jersey's hospitals were phased into the DRG system over a three year period: 1980, 1981, and 1982. According to the New Jersey Health Department the average length of stay in 1979 (pre-DRG) for the seven most common types of licensed hospital beds was 7.43 days; this figure dropped to 7.0 days in 1982 and decreased further, to 6.39 days in 1983. (By comparison, the Department of Health and Human Services reports a reduction in average length of stay in the Medicare program from 9.5 days to 7.5 days after the first full year of the federal prospective payement system.)

   In a data report, compiled in cooperation with the New Jersey Department of Health, the Home Health Agency Assembly of New Jersey found that the number of admissions to home health agencies from hospital jumped from 61% to 68% of total admissions between 1980 and 1981, the first year of phase-in for the DRG system in New Jersey. Since 1981, hospital referrals have remained a constant 67% of total admissions for home health care. The net impact of the DRG system is an increase of 8,000 admissions to home health care in 1983. There were a total of 133,000 persons served by home health agencies in New Jersey in 1983.

2. Home health agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges.

   Over the same four year period during which the average length of stay steadily dropped, the number of high technology services offered by home health agencies grew dramatically. According to 1983 data, the following services were offered by a significant number of home health agencies.

TYPES OF PROGRAMS AVAILABLE (1983)

	NUMBER	PERCENT
Home Catheter Care	50	98.0
Tracheostomy Care	45	88.0
Intravenous Therapy	26	51.0
Respiratory Therapy (MIA Respirator)	17	33.0
Chemotherapy	13	25.5

3. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

   The trend to expanded hours of operation, both business hours and service hours, is the most striking change in home health agency operations since the implementation of the DRG system. Eighty-two percent of home health agencies in New Jersey schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

Other studies have been released recently that provide further evidence that DRGs are causing earlier discharges of patients who often have not been given sufficient time for conditions to stabilize. A study of data from the Health Care Financing Administration, conducted by the Senate Special Committee on Aging, reported a 37% increase in discharges from hospitals to HHAs because of DRGs. A study by the Southwest Long Term Care Gerontology Center observed a 196% increase in HHA skilled nursing services that had to be provided after DRGs. University of Virginia researchers reported on the 27.5% increase in the intensity of home care services needed by beneficiaries because of DRGs. In a survey recently conducted by NAHC of 2,100 Medicare-certified HHAs, 92% responded that DRGs had resulted in a sharp increase in the number of sicker patients requiring intensive medical or nursing care. Finally, the Office of the Inspector General released a report in March, 1986 finding that "it is apparent that occurrences of premature discharges and inappropriate transfers do exist." There is no longer any question that DRGs are having a very significant effect on the need for more intensive home care services.

Impediments to the Delivery of Home Care Services

Despite the documented increase in demand for home care services created by the DRG system, the Health Care Financing Administration has sought to curtail the Medicare home care benefit, citing this very increase in use of home care services as justification for developing excessively stringent regulations and policies to govern the home health program. The following administrative actions undertaken by HCFA illustrate some of the impediments to the delivery of home care services to Medicare beneficiaries:

1. Cost Limits

On July 5, 1985, HCFA published a final rule which radically altered the way in which home health cost limits are calculated under Medicare. While cost limits were previously set at the 75th percentile of aggregate agency costs, the rule required HHA limits to be set at 120% of the mean of visit costs in six separate disciplines, explicity disallowing aggregation, or, averaging out, of these costs. Without being able to aggregate their costs, agencies management flexibility is being limited; high technology and other costly services are being severely limited or not offered at all; new and rural agencies are being hard hit; agencies are being forced to deny access to "heavy care" patients; the level of paperwork has increased dramatically; the quality of care is suffering because agencies can no longer offer a full range of services from a total patient care approach, are being forced to dismiss their tenured employees and hire less experienced personnel; and the amount of indigent care received is being reduced sharply.

Further, NAHC has recently learned that HCFA intends to use FY 1983 data for determining the new July 1, 1986 cost limits, to be calculated at 115% of the mean of visit costs. This poses a serious problem, since the FY 1983 data does not take into account the impact of the DRGs, the implementation of the new forms HHAs have been required to use, or the 34% increase in the number of new agencies providing service between 1983 and 1984 and the resultant change in the case mix.

2. Gramm-Rudman-Hollings Cuts

In order to enforce the Gramm-Rudman-Hollings Balanced Budget Act 1 percent Medicare benefit cutbacks, HCFA's intermediaries have been instructed to withhold 1% of claims and periodic interim payments (PIP) for HHAs beginning with bills showing services rendered on or after March 1, 1986 and until September 30, 1986 -- the balance of the federal fiscal year.

The 1 percent cuts are particularly devastating to HHAs since they are cost-reimbursed, and have no way of making up the loss. In effect, HHAs are being required to subsidize the Medicare program. These cuts, combined with the lowered cost caps and the inability of HHAs to aggregate costs, are paralyzing HHAs' ability to deliver a full range of quality services to beneficiaries.

3. Restrictive Interpetations of the Intermittent Care Requirement

In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24 hour-a-day care. The present guidelines allow for daily visits for a maximum of three weeks. Thereafter, visits may be continued upon a showing of exceptional circumstances. Moreover, the guidelines have permitted more than one visit to the same patient on the same day, perhaps one visit from a nurse and another from an aide depending on a showing of need. Information collected from a number of states indicates that various restrictive interpretations of the term "intermittent" are being imposed by some intermediaries. In some instances, it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances, clients who are in need of and who receive services 5 or even 3 days a week are being deemed as in need of daily care and therefore not compensable. There are even reports that such determinations made in the present based on restrictive interpretations are being applied retroactively resulting in retroactive denials.

The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy and other services into the hands of home care agencies who are being told that they cannot care for them because they need more than intermittent care. With the hospital prospective payment plan in effect, the problem has been exacerbated, with patients being released from hospitals more quickly and in sicker condition.

Definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly and what is covered for one beneficiary in one state is not covered in another state.

4. Selective Billing - Barriers to Coordination of Benefits

Fiscal intermediaries - with the approval of central HCFA's Bureau of Eligibility, Reimbursement and Coverage -- are advising HHAs that if patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid, or any other payment source (private insurance, self-pay, Title XX, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

Medicare's logic for such denials is that if a person receives care beyond what Medicare will cover, then the person needs more than "intermittent care" and is ineligible for Medicare coverage. Thus, Medicare is seeking to both prescribe the need (i.e., the limits of intermittent care) and to be second payor. This approach limits the availability of service to beneficiaries and the availability of payment sources to benficiaries and HHAs. Furthermore, the Medicare intermediaries will deem this a "technical" denial depriving the HHA of a right of appeal.

5. Delays In Processing and Payment of HHA Claims

One of the biggest problems facing HHAs under Medicare concerns widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted. Delays of well over 120 days have been reported this year by home care providers thoughout the country. The resultant cash flow problems that this has caused has rendered numerous providers unable to meet their payrolls. To date, NAHC has received reports from the states of Texas, California and Illinois that several providers were forced to put their agencies up for sale because of this problem. In a survey conducted recently by the Louisiana Home Health Association, 18 percent of the respondents reported that they had not received Medicare payments in over 120 days. Two agencies reported that they were owed more than $300,000 each. Similar examples from at least 20 other states have also been documented.

In an effort to get uniform national data on the extent of this problem, NAHC is in the process of completing a nationwide survey on the HHA claims payment delay problem. With 237 agencies across the country responding so far:

- 77 percent reported that, since September 1, 1985, they have noticed an appreciable delay in the time it takes Medicare to pay a claim.
- 74 percent report that, during the past 6 - 9 months, the average lag time between the date claims are submitted and the date payment or denial is received is 2 months or more.

The cash flow prblems caused by these delays are having a more significant adverse effect in the home health area than for any other type of health provider. This is true for four reasons: (1) Claims processing delays were already longer for HHAs than for other providers. The HCFA "Intermediary Bill Processing Time Report" shows that the time taken to process bills for HHAs exceeded those of inpatient, outpatient, and skilled nursing facilities; (2) HHAs rely on

Medicare payments, on average, more than other health care providers. Medicare accounts for approximately two-thirds of HHAs' revenues, with many agencies relying 100% on the program; (3) HHAs tend to be smaller businesses than other health care providers, making it more difficult to borrow money against capital and (4) HCFA has vastly increased administrative and other costs to HHAs over the past year while reducing total reimbursement rates. Hospital DRGs have also resulted in patients needing higher acuity, more expensive home care services, while HCFA continues to use FY 1983 data (just before DRGs went into effect) for computing cost limits.

After an agency submits a claim for payment, it continues to provide Medicare services even if payment is delayed extensively. If the claim is denied months after it is submitted, the agency may well have incurred additional expense for months of additional services. However, the agency is not permitted to turn around and bill the patient for the services rendered. Rather, the facility must take a loss, or "eat" the cost. Thus, when coverage determinations are delayed, thousands of dollars worth of potential revenues are lost; whereas, if determinations are made promptly, within 30 days, the agency has the option of billing the patient for subsequent services and is not forced to take such massive losses.

6. Other Administrative Initiatives Impeding the Delivery of Home Care Services

A March 19, 1986 report to Congress prepared by NAHC, entitled "The Attempted Dismantling of the Medicare Home Health Benefit" chronicles the barrage of administrative actions designed to restrict services and undercut the benefit promised to senior and disabled citizens under the Medicare law. We would be pleased to make this report available to the Committee or to include it in the record for this hearing. The report discusses, in addition to the items previously covered, other impediments to the delivery of service:

* New coverage compliance review criteria were issued in December 1984, establishing review on a non-random sample basis and placing increased scrutiny on "homebound" status and home health aide utilization.

* A manual revision was issued in April 1985 which allows fiscal intermediaries to use statistically invalid and unreliable sampling techniques to select a sample of claims for review to determine an agency's waiver status.

- A new set of "minimum data element" forms (HCFA Forms 485-488) have been implemented which will increase the level of claims undergoing medical review to over 50 percent. Due to a poorly-designed set of computer specifications for use in processing these forms, intermediaries will be performing the increased further level of medical reviews on a mainly manual basis, thus further slowing down claims processing and cash flow.

- In the midst of implementing new data element and billing forms, HCFA will be instituting a new regional intermediary system shifting 85 percent of all HHAs from their current intermediaries (there are 47 statewide intermediaries now) to a regional system of ten intermediaries.

- An accounting policy on "discrete costing" is in effect which discourages HHAs from diversifying into non-Medicare program areas at the risk of having the non-Medicare programs absorb a disproportionate share of overhead created by the Medicare program.

- HCFA proposed, in President Reagan's FY 1987 budget, to impose a copayment equal to one percent of the inpatient hospital deductible. If implementated for FY '87, this would mean beneficiaries would pay a $5.00 copayment for each of their home health care visits.

- A January 1984 manual change prohibits beneficiaries from designating HHA employees as their representatives in claims denial appeals.

- A policy has been instituted whereby HCFA, through its intermediaires, can use a questionable sampling methodology to sample claims and project the denial rate to an agency's entire caseload resulting in a demand for repayment prior to any appeals.

- HCFA will not pay for home intravenous antibiotic therapy supplies, equipment or services.

- HCFA will pay for home intravenous chemotherapy supplies, equipment and services only on a very limited basis.

The Medicare Quality Protection Act of 1986

The Medicare Quality Protection Act of 1986, S. 2331, is legislation that would go a long way in improving the quality of care Medicare beneficiaries receive and in assuring that they are cared for in the most appropriate health care setting. In particular, we are pleased that provisions are included which would facilitate appropriate transfers from hospitals to HHAs and improve the administrative mechanisms for determining Medicare coverage. NAHC supports the legislation and will assist in working towards its enactment.

The following is an analysis of Title II of the legislation: "Access to Appropriate Post-Hospital Care." The analysis will go through the Title section by section:

Section 201 - Requiring Hospitals to Provide Discharge Process

NAHC supports discharge planning as an integral process in assuring continuity of care for Medicare beneficiaries and other hospital patients. For those few hospitals that do not have a formal discharge planning program, it is not unreasonable to require it as a condition of participation. Absence of discharge planning can create serious placement problems for those ready to leave the hospital. It has become an indispensable part of the services provided by the hospital.

Section 202 - Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services

NAHC supports extending waiver of liability coverage to so-called "technical" denials based on homebound or intermittent care requirements. These requirements are subject to the same vagaries as the policies governing medical necessity determinations, which of course, are covered by the waiver. The nature of these "technical" denials will be discussed in greater detail in the analysis of Section 207.

A problem that is likely to arise under this provision is that Medicare coverage denials will increase to a level over 2.5 percent of claims submitted. Therefore, many HHAs could lose their waiver status completely unless the 2.5 percent figure were adjusted upward, since "technical" denials are not currently part of the computation of the 2.5 percent. Since fiscal intermediaries (FIs) have increased the number of "technical" denials as of late (for example, during the first quarter of 1986, 33% of all denials received by providers in Oklahoma were "technical", while in 1985, only 5% were "technical") extending waiver in this manner will almost surely push the denial rate for many HHAs over 2.5 percent. We, therefore, recommend that the waiver threshold be raised to 5 percent for HHAs. This would make the level equal to that for SNFs. There is no reason to make any distinction between the two. With HHAs shifting to a system of ten new regional intermediaries, it is particularly important that the waiver threshold be increased to 5% so that providers won't lose their waiver as they adapt to the differing interpretations of the Medicare regulations and guidelines for their new FIs. If Section 202 is passed without increasing the threshold to 5%, the net effect will be counterproductive, in that more and more HHAs will lose their waiver status. We would also recommend that other types of "technical" denials, such as failure to meet residence requirements and denials for dependent services (i.e., home health aide, medical social work) be included under Section 202.

Section 203 - Continuing of Favorable Presumption of Waiver of Liability for Skilled Nursing Facilities and Home Health Agencies

The waiver presumption was placed in the law to protect providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated. In these cases, the Medicare program does nothing more than make the provider whole.

In the home health setting, in order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of the Medicare services given. Any agency which exceeds this limit is not reimbursed irrespective of whether it accepted beneficiaries and acted in good faith. This requirement forces an agency to use due diligence in determining eligibility.

The Consolidated Omnibus Reconciliation Act of 1986 (COBRA) included a provision which would preserve the waiver presumption for HHAs for a year after the new 10 regional intermediaries for HHAs are all operational. After this time the waiver would be eliminated. NAHC strongly supports this provision which would make the waiver of liability permanent. Eliminating the waiver would serve to further undermine both the public and provider confidence in the Medicare program. It would make accepting Medicare patients a kind of "Russian Roulette" at a time when more rather than less certainty and predictability is required. Medicare beneficiaries are particularly concerned that the elimination of the waiver of liability will reduce their access to home health services and increase their out-of-pocket costs for these services because providers will be discouraged from accepting patients for all but those services sure to be covered. Given the vague application of constantly changing guidelines, directives, and regulations, it is difficult for HHAs to be 97.5% perfect in their determinations of eligibility. Removing this requirement would demand that they be 100% perfect in their determinations or suffer accordingly. Again, NAHC believes Congress should restore the more realistic 5% rate of permissible error previously in law.

Section 204 - Development of Uniform Needs Assessment Instrument

NAHC agrees that we need to take a closer look at examining and developing a better uniform needs assessment instrument for determining Medicare coverage of HHA services. The current mechanism results in inconsistent, arbitrary denials of coverage, in part, because such terms as "homebound" and "intermittent" are so vague and open to many varying interpretations among FIs.

It is all the more important that we open up debate on this issue because the types of patients HHAs are now seeing after a hospital stay are much different from those that were seen when the Medicare home health benefit was first enacted. For example, because DRGs are pushing people out of the hospital in a sicker, more unstable condition than in the past, the "intermittent" care requirement may no longer be appropriate.

This requirement essentially demands that the patient must not be "too sick". He or she must need care intermittently, as opposed to on a full time basis. Patients who need care more frequently than on an intermittent basis, are thought too sick to be cared for at home and should be in a nursing home. This, of course, makes no sense a a matter of public policy particularly in light of the impact of DRGs. First, HHAs are presently caring for individuals on a full-time basis when supported by non-Medicare payment sources. Second, nursing home care is not a viable option. Few people qualify for such care under Medicare. Third, if neither home care nor nursing home care are available, the ultimate effect is to leave individuals who are in need of health care to fend for themselves.

Without question, current coverage guidelines and criteria must be reviewed. There must be a better way to determine accurately and predictably whether a patient is in need of home health services under Medicare. The Advisory Panel and Report to the Secretary are appropriate measures for addressing this issue, given the complexity and importance of these deliberations.

Section 205 - Expedited Review by Fiscal Intermediaries

As previously discussed, probably the biggest problems facing HHAs under Medicare at present concern widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted.

We are pleased that this provision reflects a sensitivity to this problem. However, the terms "expedite" and "minimize" are not defined. This vagueness weakens the intent of the Section, since an expedited disposition could be interpreted to mean 90 days, as opposed to 120 days. Our primary concern with this provision, however, is the lack of any enforcement mechanism to ensure that these procedures are followed. Without such an enforcement mechanism, FIs will be able to ignore this provision and unreasonable delays will continue. We do not believe that a change in or addition to the Contractor Performance Evaluation Program (CPEP) would suffice because the bias in this program towards cost savings will still vastly outweigh any such provision. Rather, some form of financial incentive, such as paying interest after 20 days, could be required to give this important provision some teeth. On the whole, however, NAHC supports this section.

Section 207 - Provider Representation of Beneficiaries on Appeal of Certain Technical Denials

NAHC considers Section 207 to be the most important provisions for home care providers in this legislation. It addresses two for the most grossly unfair rules under the Medicare home health benefit, which have plagued beneficiaries and providers alike.

NAHC continues to press for the right of a patient to elect to have a Medicare provider represent him in the claims denial process. The selection of a HHA as a beneficiary's representative was acceptable for many years until HCFA issued a revised manual provision (Section 257A.1 - HIM-11) blocking the exercise of fair hearing rights for Medicare beneficiaries. These individuals are frequently unable from a practical and medical viewpoint to handle the taxing requirements which are part of the claims denial and the appeals process. The HHA has traditionally served as a medical and emotional support for these people and is frequently in the best position to know and represent the patient's medical needs in the appeals process. NAHC was extremely supportive of the provision in the Budget Reconciliation Act of 1986, which would have permitted provider representation. Unfortunately, under pressure from the Office of Management and Budget, the provision was deleted. NAHC is very pleased to see this issue addressed here.

When terms like "homebound" and "intermittent" directly relate to medical orders which physicians sign to permit HHAs to render care under the home health benefit, and to the medical and nursing assessments of the patients which the HHA must perform on an ongoing basis, the HHA should have the right to appeal such denials directly. Medicare beneficiaries rely upon the medical and nursing assessments of the HHA, and the HHA relies upon the patient for accurate information about the patient's activities and subjective responses to treatment. HCFA's "technical" denial policy fractures this relationship of caregiver and patient and is an illogical interpretation of the statute as now written.

NAHC believes HCFA's "technical" denial policy is another attempt to create Medicare "savings" because HCFA is aware that most Medicare patients, their families or survivors may lack either the understanding or the stamina to appeal a "technical" denial on their own. It is simply not realistic for HHAs to expect or even attempt to recoup from frail people in strained financial and emotional situations the costs of months of care disallowed by FIs. Having already paid staff salaries, HHAs are left with tremendous financial losses.

The Medicare beneficiary is harmed since the HHA which rendered care is barred by current HCFA policy from joining in or leading the appeal. Medicare beneficiaries are also adversely affected because HHAs facing severe monetary losses from "technical" denials must avoid care of patients whose care might result in a "technical" denial. For example, most technical denial cases on the "not intermittent" care issue are won by patients at the impartial administrative law judge level.

However, HHAs cannot be confident that these appeals will be brought by sick, exhausted patients or bereaved families. HHAs will begin to limit the number of these patients, or cut back on needed visits, or simply not bill for visits that are made - which no business can afford to do for long. The result is an inevitable narrowing of the Medicare home health statutory benefit, just at the time when doctors and Medicare beneficiaries are relying more heavily on HHAs to provide post-hospital care.

Section 208 - Including in Annual Reports on Prospective Payment Information on Quality of Post-Hospital Care

NAHC supports this provision. It will help Congress to ensure that it objectives are being met and that HCFA is not disregarding clear guidelines to make high quality Medicare home care services accessible to beneficiaries.

Recommendations to Assure the Availability of Quality Home Care Services to Medicare Beneficiaries

In addition to its support of the Medicare Quality Protection Act of 1986, NAHC recommends that other corrective legislation be enacted to ensure the availability of quality home care services:

> NAHC supports S. 2494, introduced by Senators Bradley, Heinz, and Glenn, which would restore the ability of of HHAs aggregate costs, mandate hospital discharge planning, and require HCFA to follow the Administrative Procedures Act.
>
> NAHC supports S. 778, introduced by Senator Heinz, which would define intermittent care to include up to 60 days of daily care and thereafter under exceptional circumstances, with monthly physician certification that care is reasonable and necessary.

Mr. Chairman, I appreciate having this opportunity to testify today on these important matters. I would be pleased to answer any questions you might have.

STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman. I would like to discuss two phenomena—the first one ever so briefly. The two phenomena being the sicker-quicker issue and the no-care zone issue.

The sicker-quicker issue I would discuss only to the extent that what we are saying is, in fact, the prospective reimbursement system working is exactly as intended. The costs were to be reduced not only by providing fewer services within the days of hospitalization, but by reducing the number of days itself. That is what is happening. And as one moves out of the hospital quicker, one is almost by definition sicker as well.

I would like to spend more time on the no-care zone issue. We seem to be surprised that, as Senator Heinz has suggested, patients following discharge are falling into a no-care zone. Why should it surprise us? The no-care zone results largely from the design flaws in the Medicare program itself as it relates to skilled nursing facilities.

Back in 1965, the design flaws began. I am not even speaking of the 100-day maximum benefit for a skilled nursing stay or the 3-day prior hospitalization requirement which has not kept up with advances in medical technology. I am referring to such things as the fact the nursing home providers are basically reimbursed, even with the changes made by Congress last year, through a cost-reimbursement system which guarantees a loss for those patients in all but the largest nursing homes with heavy Medicare volume. Medicare reimbursement is based on facility costs, it does not reimburse Medicare costs. The higher costs for a few Medicare patients are averaged and weighted down with the lower costs of the majority of patients with lighter care needs.

Those providers who do participate, despite that inadequate reimbursement, must still contend with an onerous paperwork system and cost report, oriented largely to the hospital industry. My members have difficulty understanding why they have to attribute pediatric costs—There aren't many pediatric patients in nursing homes.

But Congress has not quit. As recently as last year, they have taken a badly designed system and made it even more unlikely that nursing homes want to participate. My colleague from the home care industry has suggested some of those problems. One of them was that nursing homes would have their return on equity reduced by 33 percent. Another was that their Medicare reimbursement for capital costs would remain frozen under the asset revaluation provision, although changed for Medicaid. But the coup de grace, I suspect, was Gramm-Rudman, which assures even those masochists who have stayed in the Medicare Program that under no circumstances, no matter how efficient they may become, will their total costs be reimbursed. They will be reimbursed at the level of 99 rather than 100 percent.

And I think it is not surprising, therefore, that of 9,000 skilled nursing facilities in this country, only 65 percent are even certified for Medicare, and only 40 percent actually admit Medicare patients. In one-half of America's rural counties, there are no SNF's. In three or four States, there are only one or two SNF's that participate in the program, whereas six States provide 50 percent of all SNF days in this country. Frankly, we have a very limited benefit, which is not available in most States to the Medicare patient.

And let's not forget the role of the executive branch in this tale of woe. The executive branch encourages Medicare claims denials by requiring fiscal intermediaries to deny $5 in claims for every $1 they receive for claims review. The executive branch has tried to remove waiver of liability on claims denials and although now prohibited by Congress from doing so directly by regulation they will continue to try to do so indirectly by more restrictive medical criteria. They have fouled up claims processing by directing intermediaries to slow down processing, causing providers to resubmit claims and double the paper jam.

We do have a problem. There is a no-care zone, and it is going to, in all likelihood, get worse unless we take a look at the SNF benefit and try to structure it in a way appropriate to the needs of the beneficiary. For example, did Congress intend for even the small 100-day SNF benefit to become, in effect, a 20-day benefit, which it has as a result of escalating patient cost sharing. Cost sharing in the nursing home after the 20th day is now higher than most of the payments made by Medicare to the nursing home.

Let's look at the possibility of extending Medicare prospective reimbursement beyond the low-volume providers which Congress did last year; and let's look for the possibility of going even beyond permanence for waiver of liability to possibly a prior-approval system for coverage decisions. Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you very much.

[The prepared written statement of Dr. Willging follows:]

Statement of the
American Health Care Association

Medicare Changes to Assure the Quality
and Availablity of Skilled Nursing Care

by

Paul R. Willging, Ph.D.
Executive Vice President

before the

Committee on Finance
U.S. Senate

June 3, 1986

Mr. Chairman and Members of the Committee:

I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing America's long term care providers. AHCA's membership exceeds 9,000 nursing homes, many of whom provide skilled nursing facility (SNF) services under the Medicare program.

The problem of patient access to needed Medicare skilled nursing facility services, a longstanding problem in most areas of the country, is worsening because of Medicare hospital payment incentives for more patient transfers to SNFs and earlier transfers involving sicker patients. Indeed, with hospital discharges to skilled nursing facilities having increased by 40 percent in the past 2 years, the need to look at the entire continuum is essential.

Unfortunately, while Congress focused its attention on the Medicare acute care area, it sorely neglected the skilled nursing facility component which was now being pressured to provide follow-up services to these hospitals' newly discharged, often more acutely ill patients. Nothing was done to the SNF benefit so that this component of the Medicare package could accommodate the predictable effects on hospital utilization. The evidence is overwhelming that the Medicare SNF system is broken, but it can be fixed.

I want to acknowledge and applaud the leadership of the Chairman and members of this Committee for beginning to address the Medicare SNF access problems and related Medicaid nursing home issues in the recent Consolidated Omnibus Budget Reconciliation Act (COBRA). The most significant COBRA provisions provide a Medicare prospective payment for SNFs with a small number of Medicare patients, a moratorium on Administration efforts to eliminate Medicare's "waiver of liability" for providers acting in good faith to serve beneficiaries' post-hospital needs, and a modification of Medicaid's authority to recognize, at least partially, legitimate increases in property costs. It is vital that further steps to improve patient access be enacted this year, and AHCA appreciates the opportunity to work with this Committee in continuing your commitment to Medicare beneficiaries.

NEED FOR NEXT MEDICARE STEPS

Despite public perceptions, Medicare coverage of nursing home care is scant. Medicare nursing home coverage is for only up to 100 days of care per spell of illness, is limited to patients who have had at least three days of hospital care, and only in a skilled nursing facility -- the most intensive level of nursing home care. In reality, this small benefit is further diminished by Medicare's "fine print", notably restrictive medical eligibility criteria and excessive patient cost sharing. As a result, Medicare paid 1.9 percent of the nation's nursing home costs in 1984.

Need to Attract More SNF Participation

A primary barrier to Medicare patient access is the burdensome and inefficient reimbursement system for SNFs that acts to discourage facilities from choosing to participate in Medicare. Medicare pays for SNF services on a retrospective basis -- after the service is provided, a preliminary payment is made to the facility and a final payment is calculated approximately one year later based on cost reports submitted by the facility. Less than 1/3 of the nursing homes have even sought Medicare certification. Medicare SNF access is so concentrated that half of all patient days are provided by less than 500 facilities, out of over 16,000 nursing homes in the nation. As a result, many Medicare beneficiaries in need of SNF services are unable to receive appropriate care, often "backed-up" in expensive hospitals longer than medically necessary awaiting SNF placement.

The Consolidated Omnibus Budget Reconciliation Act took a significant step in encouraging greater participation in Medicare by facilities providing less than 1500 annual Medicare days of service. These facilities will have the option of accepting a fixed per diem payment based on the SNF costs in the region, along with a substantially reduced cost report.

AHCA encourages the expeditious development and implementation of a prospective payment system for all SNFs under Medicare. With an appropriate prospective system, the Medicare program can achieve significant savings and enable beneficiaries to receive the appropriate services in the least costly setting. A prospective payment system would attract more provider participation in Medicare and respond to the increasing demand for Medicare SNF service resulting from hospital discharge incentives. This system is necessary to facilitate the continuity of post-hospital care and avoid a hospital "back-up" crisis.

As you recall, we have recommended a transitional prospective plan for SNFs under Medicare which would make immediate improvements in patient access and serve as the most expeditious way to develop the refinements of an ideal system. Specifically, AHCA urges Congress to adopt the remainder of our transitional plan as the next major step toward the development of a case-mix system. In brief, AHCA's transitional system features the following:

- Prospective rates covering all operating and most direct patient care expenses. Rates would be based on a facility's reported costs, indexed forward, up to a ceiling fixed by the costs of comparable facilities. The ceiling concept is similar to the existing "Section 223" limits on routine costs.

- Per unit payment for a small number of special ancillary services (e.g., therapies) with high cost and highly variable utilization. Currently, certain services are separately paid.

- Efficiency incentive payments for keeping costs below the ceiling. A facility would receive a proportion of the difference between the ceiling and its prospective rate, limited to a percentage of the ceiling.

- The prospective rate and ceiling computations would include actual capital costs paid plus a simple percentage add-on for growth and return on investment.

- Simplified cost reports and the burden of cost reports eliminated for SNFs with a low number of Medicare patients.

The move toward a fully prospective SNF payment takes on greater urgency because of the perversity of Medicare sequestration under the new Gramm-Rudman deficit cutting process. For SNFs and other cost-reimbursed providers, the Gramm-Rudman procedure is to reduce Medicare to being a "less than cost" payor.

Since March 1, SNFs have been reimbursed only 99 percent of actual costs, regardless of the amount of their costs or whether their costs are increasing, decreasing or the same. If the Gramm-Rudman automatic cuts are again triggered, payments could be cut down to 98 percent of actual costs. A more constructive way to achieve needed Medicare cuts is to make targeted reductions. To the maximum extent feasible, Medicare savings required under Gramm-Rudman sequestration should be achieved by lowering reimbursement limits or related to past costs. For example, to achieve the March 1 sequestration it would have been more purposeful to have lowered the "Section 223" limit on routine operating costs, thus encouraging greater efficiency from the high cost providers, than to shift every SNF to "less than cost" reimbursement.

Need to Reduce Patient Costs for SNF Care

Another priority issue for Medicare patient access must be reduction of the SNF patient cost sharing. Medicare SNF patients pay $61.50 per day in coinsurance from the 21st to the maximum 100th day of care. To use the full SNF "benefit" a Medicare beneficiary would have to pay a coinsurance of $4920, and this is on top of a minimum prior hospitalization charge of $492. This $61.50 fee exceeds the Medicare payment to a SNF in most areas of the country. In effect, the high SNF coinsurance eliminates the value of Medicare coverage beyond the 20th day.

Present cost sharing for SNF patients is punitive, especially relative to other Medicare services. Although we appreciate the Committee's interest in moderating the increase in Medicare Part A patient costs because of the highly visible hospital deductible, we urge an actual reduction in the patient's cost burden for SNF care. In contrast, home health recipients pay nothing and hospital patients pay a deductible of $492 for the first 60 days. And, when a SNF prospective payment is implemented, SNF coinsurance should be set at a percentage of the SNF payment rate and not be artificially linked to hospital costs.

Need to Eliminate SNF Admission Barrier

Another barrier which should be eliminated is the requirement that to qualify for SNF services, beneficiaries must first spend at least three days in a hospital. With the strong incentive for hospitals to increase admissions and make transfers as early as possible, elimination of the prior hospitalization requirement takes on added importance.

Although a provision in the Tax Equity and Fiscal Responsibility Act of 1982 directs the Department of Health and Human Services to waive the three-day prior hospitalization requirement when such a waiver would not lead to an increase in costs, HHS has taken no action on this issue to date.

Need to Assure Continuity and Quality of Service

We appreciate the Committee's interest in our views on S. 2331, the Medicare Quality Assurance Act, which was introduced by Senator Heinz, with a House companion bill by Rep. Stark. Although the focus of the Heinz bill is directed towards improving the appropriateness of discharge of beneficiaries from hospitals, it also refers to an equally serious problem which relates to the adequacy and availability of appropriate post-hospital care.

Our concern, however, is that S. 2331 does not go far enough. We would ask you to consider some of the proposals in a bill introduced by House Aging Committee Chairman Roybal, the Medicare Continuing Care Equity and Quality Assurance Act (H.R. 4330). This bill complements S. 2331 by addressing access and quality of long term care services. AHCA urges enactment of the Roybal bill together with most of the Heinz-Stark provisions. The following are recommendations about the provisions of S. 2331 which relate most directly to long term care.

Section 106 -- Administratively necessary days

We believe the focus of the proposed HHS study required in this section is misdirected. The study is directed at the symptoms rather than the root problem -- the severe shortage of Medicare SNF beds. We believe hospitals' "administratively necessary days" should be reduced rather than accommodated. We recommend the study focus on mechanisms to develop sufficient SNF access and assure appropriate post-acute placement.

As a short-term improvement, we recommend a proposal in H.R. 4330 which would make special arrangements for beneficiaries who are eligible for SNF care, but for whom a bed is not immediately available. The provision requires that the Department of Health and Human Services (HHS) set standards, assess criteria and payment rates to permit Medicare home health agencies and Medicaid intermediate care facilities to provide care only if the possibility of continued hospital stay is ruled out, only when the professional review organization (PRO) certifies that the patient's health and safety can be reasonably assured at the lower level of care, only when the patient and their physician agree to the alternate care setting and only until a SNF bed becomes available. AHCA believes that Medicaid skilled nursing facilities should also be used to provide such interim care.

Section 203 -- Waiver of liability

AHCA was pleased that the Medicare waiver of liability protection for SNFs and home health agencies was safeguarded by the Consolidated Omnibus Budget Reconciliation Act. However, continuation of this practice, as proposed in S. 2331, will not solve the problem of unpredictable retrospective denials of claims.

We believe a prior authorization system is a more innovative and needed approach. Such a system would reduce costs incurred by beneficiaries during the claims review process and inform providers prior to or during provision of services as to Medicare eligibility rather than after the fact. For example, H.R. 4330 would establish a presumptive eligibility period and a concurrent, 10-day claims review period for services claimed within a class of benefits.

Section 204 -- Uniform needs assessment instrument

AHCA endorses the development of a needs assessment instrument which can be used to evaluate an individual's need for SNF and other long term care services. This could be a useful tool for discharge planners, providers and fiscal intermediaries. This proposal coincides with a recommendation in the recent Institute of Medicine study on nursing home regulation.

We believe that uniform criteria for medical claims review, as proposed in H.R. 4330, should also be considered. It is essential that judgment of Medicare coverage be made in a consistently objective way and uniform criteria would facilitate such a process. In addition to serving as an assessment protocol for patients, the mechanism could set qualifications for personnel employed to perform medical reviews under Medicare.

Section 205 -- Review by fiscal intermediaries

AHCA supports the development of an expedited review process which will minimize the time between when Medicare services are provided and when determination of coverage is made.

Section 206 -- Prompt response to inquiries concerning exhaustion of Medicare SNF benefits

AHCA strongly supports this provision.

Section 207 -- Provider representation of beneficiaries on appeals

AHCA supports allowing beneficiaries to choose to be represented by their provider in appealing Medicare claim denials. In so doing, protection is given to the right of Medicare beneficiaries to select freely their most competent representation for the claims appeal process. AHCA supported this provision in last year's budget reconciliation bill and regretted its elimination prior to final passage.

Section 208 -- Prospective payment reports to include information on quality of post-hospital care

AHCA strongly supports this proposal and recommends the establishment of a Continuing Care Policy Council, as proposed in H.R. 4330, which would report to HHS regarding the development and interpretation of definitions, policies and regulations under Medicare's continuing care benefit.

Section 302 -- PRO review of quality of care

AHCA is concerned about direct involvement of the peer review organizations in the review of quality of care in nursing homes and board and care facilities. PROs were established to conduct reviews in hospitals and we believe their primary responsibility should remain in acute care.

Current law requires Medicare and Medicaid evaluations of the quality of care provided nursing home residents and of the appropriate and efficient utilization of facility services. These "inspections of care" are a comprehensive quality assurance program for long term care facilities. Therefore, another layer of quality assurance in long term care by PROs is not needed.

The mechanisms already established by the states should be the primary mode of quality and utilization review in Medicare and Medicaid nursing homes.

However, in some cases, the PROs may observe patterns of poor or inappropriate care in long term care facilities. Accordingly, they should be required to refer these problems to the appropriate state and/or federal offices.

Section 401 -- Strategy for quality review and assurance

AHCA supports development of a strategy for reviewing and assuring the quality of long term care, but we believe that the proposed study should be limited to hospitals which provide services under Medicare.

The Institute of Medicine recently completed a thorough study of the nursing home regulatory system. Representatives of consumers, providers and government agencies worked together over a 2-1/2 year period to develop recommendations which would contribute to improved quality of care and well-being of nursing home patients. The study provides an appropriate backdrop for a number of the long term care proposals contained in S. 2331 and many of those in H.R. 4330.

Need to Protect Patients from Inappropriate Post-acute Care

Medicare-participating rural hospitals of 50 beds or less have been permitted, since 1980, to use their acute care beds on a "swing" basis for long term care. The hospital beds may be used to furnish SNF services under Medicare or Medicaid and intermediate care facility services under Medicaid. Also, swing bed demonstration projects are authorized for all other hospitals.

AHCA believes that care for patients needing nursing home services is best provided in a nursing home unit, where patients have available the full range of medical and social services. Hospitals may set up a "distinct part" of the facility exclusively for provision of long term care. But the the swing bed program allows hospitals an inconspicuous entry into nursing home care, without having to meet the same conditions.

Of concern for Medicare spending is that the swing bed program provides hospitals an easy and financially attractive way to "game" the Medicare hospital reimbursement plan by "double dipping" -- taking the fixed, diagnosis-based payment for Medicare acute care and then swinging the patient on to cost-reimbursed SNF care.

A hospital swing bed should only be used when an appropriate nursing home bed is not available for the particular patient and only until a nursing home bed becomes available. Also, hospital swing beds should have to meet the same licensure requirements and Medicare-Medicaid conditions of participation as nursing homes.

The swing bed provision was originally designed to provide a temporary solution to a shortage of long term care beds in an area. Thus, before a hospital is permitted to swing beds, it should document that a shortage exists. But the permanent solution is to develop an adequate supply of nursing home services, rather than subjecting patients to continuous, makeshift hospital arrangements. Certainly, swing bed approvals should not be allowed in states which have placed a health planning moratorium on new nursing home beds.

Approvals for the swing bed program should be for specific levels of care -- skilled nursing and/or intermediate care, as determined by the actual bed need in an area. In some places, for example, there is a shortage of skilled nursing beds, but general accessibility to intermediate care. If a bed shortage persists and the hospital wants to continue nursing home services, a "distinct part" should be created.

AHCA urges Congress to enact restrictions on "swing beds" and to oppose expansion of the Medicare-Medicaid swing bed benefit for overbedded hospitals. Although no Senate bills have been introduced pertaining to swing beds, we would like to call your attention to a House bill which we strongly support, H.R. 1745, introduced by Rep. Sikorski.

NEED TO PRESERVE MEDICAID FUNDING FOR LONG TERM CARE

The Medicare hospital reimbursement change also affects the Medicaid program, which pays for about 30 times more nursing home patient days than Medicare and most of the Medicaid nursing home patients are also Medicare beneficiaries. Thus, it is critical to examine two related Medicaid issues.

Need to Maintain Adequate Federal Funding

We applaud Congress' rejection of the Administration's proposal to essentially freeze federal Medicaid spending for fiscal 1987 and cap its growth in later years. Congress has enacted cuts of more than $4 billion in the federal share of Medicaid since 1981. Also, states have cut the rate of Medicaid spending and will continue to contain costs in response to their own budgetary constraints.

AHCA is also opposed to further cutting the federal commitment to nursing home survey and certification activities. The Senate's budget resolution indicates support for the President's proposal to eliminate all special matching rates for state administrative activities, such as for medical personnel used for survey and certification. In 1980, Congress cut the federal share of survey and certification costs from 100 to 75 percent. Because of increasing needs to upgrade the quality of inspectors and implement the new patient care and services (PaCS) survey, this Committee should not further cut the federal share of these costs to 50 percent.

Need to Remove Medicare Limit on Medicaid Reimbursement

HHS regulations limit the Medicaid reimbursement a state can pay to nursing homes and hospitals to an amount not greater than would have been paid if Medicare principles of reimbursement were used. Although this limitation may have served a purpose when Medicaid reimbursement systems were all cost-based, that is not the situation now.

In 1980, states were given substantially more flexibility in designing their Medicaid nursing home reimbursement methods under Section 962 ("Boren amendment") of the Omnibus Reconciliation Act. The Finance Committee report indicated that the then-current Medicare "upper limit" regulations could continue, but the report language elaborated, "Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement the Secretary would only be expected to compare the average rates paid to SNFs [skilled nursing facilities] participating in medicare with the average rates paid to SNFs participating in medicaid in applying this limitation." The House reconciliation bill did not address Medicaid nursing home reimbursement and the Senate provision was agreed to in conference committee, but the conference report made no specific comment on the Medicare "upper limit".

HCFA has recently proposed regulations that would greatly limit the states' flexibility in Medicaid rate setting. HCFA wants to apply Medicare rate setting principles to Medicaid costs of small groups of facilities and is rejecting the contention that the Congressional intent was to compare Medicare rates statewide with Medicaid rates statewide. HCFA feels that the lack of statutory language on the issue gives it a freehand to limit state Medicaid rate setting by requiring comparison with the Medicare program.

AHCA believes any Medicare limit on Medicaid is inappropriate, unworkable and counter-productive since virtually every state has instituted payment plans more advanced than Medicare's retrospective, cost reimbursement system. We strongly urge a statutory prohibition of this federal Medicare imposition on state Medicaid administration.

Under the HCFA proposed regulations, states would be forced eventually to return to Medicare principles of cost reimbursement, thereby abandoning more innovative and efficient payment practices, such as prospective payment plans and incentives for serving patients with heavier care needs. A specific example of the consequences of HCFA's more restrictive approach would be to essentially invalidate the Consolidated Omnibus Budget Reconciliation Act provision which severed the connection between Medicare and Medicaid principles of reimbursement for revaluation of facility assets.

In summary, we offer the Committee every encouragement and our assistance in making Medicare changes to accommodate the hospital payment incentives and to make real the beneficiaries' largely paper benefit for skilled nursing services.

Senator **Durenberger**. Just one general question that I will ask of all of you. What is the possibility that the average length of stay in the hospitals in this country has sort of bottomed-out and maybe it is even decreasing a little bit because of several things? First, the reimbursement system, we are getting more DRG and less hospital specific; second, we are getting closer to a national average; third, we are getting to the point where we are not scared of DRG's any more, even though we complain about them; fourth, we are getting all of the efficiencies out of our hospitals that we knew we were capable of getting out of them; fifth, some of us are doing some skimming particularly on quality; and so, some of the hospitals are getting fairly comfortable in the system just the way it is.

And we are treating hospitals pretty good in this reimbursement system; but we aren't doing the same for some of these alternative providers. Is that a possible scenario as to what is going on out there? That is sort of what I would believe if I believed everything that was in the inspector general's report on hospital profits. [Laughter.]

Mr. **Owen**. Let me comment on that. I think the inspector general's report goes back—not on what is happening today—but what happened in 1984, and I think most of us knew that when this program started, there would be some operating efficiencies that hospitals could do and hospitals did it. And the purpose was not that they should make profit; the purpose was to save money for the Federal Government, which they did. So, everybody was happy supposedly; but now, all of a sudden, because they have made a profit, it is a problem.

But looking at what is happening today because, since that time we have not had the market-basket increases that Congress promised us during the period of time that we were going to move forward—all those disappeared. Skimming—as I look at what is happening with length of stay—I don't think skimming is happening at all. I think the opposite is occurring. If you were going to skim, you would see a continuation of the length of stay dropping because the only way you skim is to get the length of stay down so you make money on that case.

By keeping the case longer, you are not making more money. What I do see happening is you are getting more severe cases; the mix is changing so that you don't have the same kind of mix that you had before, because as the length of stay goes down, and you get more and more severe patients, then you are going to see a leveling off and possibly a smaller increase.

The other thing that goes with that is the age of our patients is getting greater. We are taking care of more people who are 85 rather than 65, and they take a little bit more time in taking care of them. I do think—and I agree with Paul in his statement—that when Medicare was designed, it was designed primarily for the acute in-patient care. Now, we have a system that says: Don't take care of those patients in the hospital; take care of them as out-patients or, as soon as they have passed that acute care episode, put them somewhere else—skilled nursing facility, home care, somewhere else. And at the same time, we are not providing any funds for these other agencies.

So, I think we are facing a very serious problem of continuity of care and what happens to that patient after they complete the acute care episode. They may be taken care of well in the hospital. What happens to them?

Senator **Durenberger**. Do either of you have a reaction to that?

Dr. **Willging**. I think that I and my colleague from the hospital industry are in total agreement, Mr. Chairman—not enough money is provided to the nursing home providers. [Laughter.]

I think we do have to ask ourselves, though, whether or not a program such as Medicare, enacted in 1965, has kept up with some of the other changes that have taken place. I think the point is well taken that, if we are talking about a hospital payment system that was designed to utilize alternative settings, attention must be devoted on the alternative settings, and that has not been done. I have always contended that Congress essentially fixed half of an equation but didn't bother to look at what was on the other side of the equal sign. I think it is time that Congress devote some attention to that other half of the equation.

Ms. **Cushman**. I would like to add to that that, from the home care perspective, it has now become fact that, as stated by the Health Care Finance Administration officials, that the home care Medicare benefit was never intended to take care of the more sick patient that we are now seeing discharged to us; that the acute care definition as they interpret the statute is meant to be a very limited amount of illness. As we are seeing the sicker patient, the administration is supposed to administer that care gap between the hospital and the home.

Senator **Durenberger**. All right. I thank you all and I want to express my appreciation to everyone for their participation in various ways in this hearing. I think this has been a very significant hearing. It is part of a series of hearing. I would also announce that on June 26, the Subcommittee on Intergovernmental Relations will have a comparable kind of a hearing on the issue of access. We are doing it there because this committee and the subcommittee are tied up for the summer with various other priorities and principally because of the intergovernmental nature of the problem of access. In part, it will cover some of the issues we have discussed here in terms of a continuum of care and the problems of the interplay between various levels of Government and financing access to health care.

And we want to get the State governments and local governments more involved in the process of determining how we can better finance the access for everybody in this country, particularly the elderly and the disabled to health care.

So, we thank you all very much, and this hearing is adjourned.

[Whereupon, at 1:27 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

Statement by Senator Patrick Leahy
at the Senate Finance Committee Hearing
to Examine the Quality of Health Care Under the Medicare
Prospective Payment System
June 3, 1986

I am very pleased that the Senate Finance Committee is looking into the serious allegations that elderly patients are being discharged from the hospital prematurely or, in need of post-hospital care which is not available to them, under the Prospective Payment System and the Diagnoses Related Groups (PPS/DRGs).

As well as the problems of access to, and quality of health care for the elderly created by the new system, I am equally concerned that it also puts health care providers at odds with one another.

One thing is clear--the Prospective Payment System has revealed the gaps in health care services. While acute care may be used more appropriately and efficiently under the system, we are woefully behind in continuing care services.

I feel strongly that the new system was not intended to deny Medicare beneficiaries the care they need and that some controls must be put in place to return "access" and "quality" to the Medicare program.

In response to information gathered through Congressional hearings and studies, and from the Vermont health care system and Medicare beneficiaries, I will introduce a companion bill to H.R. 4330, the **Medicare Continuing Care Equity and Quality Assurance Act of 1986** recently introduced by Congressman Roybal of the House Select Committee on Aging.

The bill is technical in nature but the result will be to put equity into the system and to promote the quality and continuity of care across service settings through reforms in Medicare claims review and appeals procedures. This applies to intermediary performance evaluation criteria and the Medicare quality assurance system, as well.

The bill will remove obstacles to receiving home health services and other types of continuing care as well as making quality assurance a condition of Professional Review Organizations (PRO) contract award and performance.

It also puts consumers in the picture by creating a national Continuing Care Policy Council to make recommendations to the Secretary of the Department of Health and Human Services, with special emphasis on the need for continuing care services. Consumers will be fairly represented on the Board.

Local consumer input with each Professional Review Organization will be assured through Consumer Advisory Boards, with the governor of each state appointing volunteer members to serve with other appropriate members.

The bill will protect Medicare patients by requiring all hospitals to have in place a discharge planning process and to establish guidelines for their use.

These are just a few of the provisions in the bill which I will introduce within the next few days.

I feel strongly that older people are not being served as well as they should be under the Prospective Payment System. But it is because of how the program is administered and not because cost containment is a bad idea.

I believe common sense and reason should be put back into the process. I am hopeful that this hearing will help to draw attention to the need for a critical look at how we are treating our older citizens under Medicare.

Mr. Chairman, I appreciate the opportunity to add these remarks to the record. Your efforts and those of other interested Senators will surely send a message to America's elderly that their health is still a high priority in the Congress, and that health cost containment measures were never intended to put them at risk.

I look forward to working with you and the members of this Committee on this very important matter.

STATEMENT
OF
RICHARD P. KUSSEROW
INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE

COMMITTEE ON FINANCE
U.S. SENATE
ON
QUALITY OF CARE FOR MEDICARE BENEFICIARIES

JUNE 3, 1986

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU THIS MORNING TO TESTIFY ON THE QUALITY OF CARE FOR MEDICARE PATIENTS. AS YOU KNOW THIS IS A TOPIC OF HIGH INTEREST TO OUR OFFICE. ONE OF THE GREATEST ACHIEVEMENTS OF THE MEDICARE PROGRAM HAS BEEN ITS ABILITY TO SUSTAIN THE HIGHEST LEVEL OF QUALITY CARE FOR PERSONS UNDER MEDICARE COVERAGE. I AM SURE THAT IT IS YOUR INTENT AS IT IS MINE AND THAT OF THE DEPARTMENT'S TO SEE THAT THIS LEVEL CONTINUES UNDER THE PROSPECTIVE PAYMENT SYSTEM.

SEVERAL YEARS AGO, THE CONGRESS AND THE ADMINISTRATION AS WELL AS THE AMERICAN PEOPLE BECAME CONVINCED THAT THE WAY WE WERE PAYING FOR MEDICARE SERVICES WAS NOT THE MOST EFFICIENT METHOD OF REIMBURSEMENT TO CARE FOR OUR ELDERLY. CONSEQUENTLY, THE CONGRESS MOVED TO A SYSTEM OF PROSPECTIVE REIMBURSEMENT WHICH PERMITS HOSPITALS TO PROVIDE QUALITY CARE TO MEDICARE BENEFICIARIES WHILE SIMULTANEOUSLY PROVIDING AN INCENTIVE TO INCREASE THEIR EFFICIENCY. AN EFFICIENT HOSPITAL, UNDER PPS, BENEFITS FINANCIALLY SINCE THEY CAN RETAIN THE DIFFERENCE IN WHAT IT COSTS THEM TO PROVIDE CARE AND WHAT WE PAY.

WE HAVE PREVIOUSLY TESTIFIED BEFORE THIS COMMITTEE ON THE ISSUE OF HOSPITAL PROFITS BASED UPON AN EARLY REVIEW OF NEARLY 900 HOSPITAL COST REPORTS. THE RESULTS OF OUR MOST RECENT REVIEW, WHICH I WOULD LIKE TO SUBMIT FOR THE RECORD, COVERS 2,099 HOSPITALS FOR 1984, THE FIRST FULL YEAR OF OPERATION UNDER PPS. THE RESULTS OF OUR AUDITS DEMONSTRATE THAT HOSPITALS ARE FARING QUITE WELL UNDER THIS NEW SYSTEM. WE PROJECTED THAT PROFITS FOR

ALL PPS HOSPITALS WAS IN EXCESS OF $5 BILLION, AVERAGING $1.3 MILLION PER HOSPITAL.

MAINTAINING QUALITY OF CARE FOR BENEFICIARIES HAS BEEN THE MAJOR COMMITMENT OF THIS CONGRESS AND THIS ADMINISTRATION. THE CONGRESS UNDERSCORED THIS POINT BY ESTABLISHING PEER REVIEW ORGANIZATIONS (PROS) TO CONTINUALLY CONDUCT REVIEWS TO INSURE THAT MEDICARE BENEFICIARIES RECEIVE MEDICALLY NECESSARY, APPROPRIATE AND QUALITY CARE DURING THEIR STAY IN HOSPITALS.

OUR WORK TO DATE FROM TWO DIFFERENT PERSPECTIVES IS SHOWING THAT THE PROCESS SHOULD PROTECT MEDICARE BENEFICIARIES FROM ABUSES UNDER THE PROSPECTIVE PAYMENT SYSTEM. FIRST, WE PERFORMED FISCAL AUDITS OF THE PROs. THESE AUDITS DEMONSTRATE THAT THERE IS SUFFICIENT FUNDS AVAILABLE FOR THE PROS TO DO THEIR JOBS PROPERLY. PROs' PROFITS DURING THE FIRST YEAR WAS AN AVERAGE OF 23.7 PERCENT AND 11 PERCENT IN THE SECOND YEAR. WE WILL MAKE A DRAFT REPORT OF THIS AUDIT AVAILABLE FOR THE COMMITTEE AS SOON AS IT IS AVAILABLE.

SECONDLY, OUR OFFICE RECENTLY COMPLETED AN INSPECTION WHICH FOCUSED ON THE PROCESS OF IDENTIFYING ALLEGED INAPPROPRIATELY TRANSFERRED OR DISCHARGED PATIENTS AND THE ACTION TAKEN TO CORRECT THOSE CASES BY THE PROS. WITH YOUR PERMISSION, I WOULD LIKE TO SUBMIT FOR THE RECORD A COPY OF THIS REPORT.

FROM OCTOBER 1, 1983 TO JUNE 1, 1985, PROS REPORTED 4,724 CASES OF INAPPROPRIATE DISCHARGES AND TRANSFERS TO THE HEALTH CARE FINANCING ADMINISTRATION'S (HCFA) REGIONAL OFFICES. TWENTY-EIGHT PERCENT OF THE STATES, PLUS THE FOUR WAIVER STATES, DID NOT REPORT ANY CASES. MANY OF THESE STATES HAVE HIGH MEDICARE UTILIZATION. FURTHERMORE, ONE PECULIARITY ILLUSTRATED BY OF OUR DATA WAS THAT PROS IN LARGE STATES REPORTED NO CASES WHILE SMALL PRO STATES REPORTED INORDINATELY LARGE NUMBER OF CASES.

IN SEPTEMBER 1985, WE COMMENCED A REVIEW OF THESE REPORTED CASES IN WHICH WE CATEGORIZED THEM BY (1) TYPE OF QUALITY ISSUE AND DISPOSITION, (2) APPROPRIATENESS OF CORRECTIVE ACTION TAKEN BY THE PROS WHEN A QUALITY ISSUE WAS IDENTIFIED, AND (3) APPROPRIATENESS OF PROCEDURES USED FOR IDENTIFYING AND HANDLING THE CASES.

BASED ON OUR STUDY, WE CONCLUDED THAT EARLY DISCHARGES AND INAPPROPRIATE TRANSFERS WERE OCCURRING, BUT NOT NECESSARILY AT AN ALARMING RATE. HOWEVER, EVEN A SMALL NUMBER OF CASES SHOULD NOT BE ACCEPTABLE. EQUALLY IMPORTANT, WE FOUND THAT THE PROS, IN FAR TO MANY CASES, WERE NOT USING EFFECTIVELY THE PROCESS TO CORRECT THE CASES AS THEY WERE OCCURRING. IN OTHER WORDS, THE PROS HAD FAILED TO INTERVENE IN SPECIFIC CASES; NOR DID THEY EDUCATE OR RECOMMEND SANCTION OF PROVIDERS WHO HAD CAUSED THE INAPPROPRIATE DISCHARGE OR TRANSFER.

MORE SPECIFICALLY, 30 PERCENT OF THE PROS HAD NOT REFERRED ANY CASES TO HCFA FOR APPROPRIATE CORRECTIVE ACTION IN A YEAR AND A HALF, EVEN THOUGH HCFA HAD IN PLACE INSTRUCTIONS AND GUIDELINES FOR HANDLING SUCH CASES. SIX STATES WERE RESPONSIBLE FOR 61 PERCENT OF ALL CASES REFERRED.

DURING THE TIME PERIOD COVERED BY OUR STUDY, PROS HAD THE AUTHORITY TO TAKE ACTION ON CASES OF POOR QUALITY CARE. HOWEVER, NO SANCTIONS WERE RECOMMENDED BY THE PROS. AND ALTHOUGH PROS IDENTIFIED QUALITY OF CARE CONCERNS IN 60 PERCENT OF THE CASES, CORRECTIVE ACTION WAS TAKEN ON ONLY ONE-HALF OF THE IDENTIFIED PROBLEM CASES. EVIDENCE STRONGLY SUGGESTED THAT THE PROS WERE RELUCTANT TO TAKE CORRECTIVE ACTION WHEN POOR QUALITY OF CARE WAS IDENTIFIED.

WE ATTRIBUTED THE LACK OF REFERRALS AND INCONSISTENCIES REPORTED, TO (1) PROBLEMS IN IDENTIFYING SUCH CASES; (2) MISUNDERSTOOD INSTRUCTIONS; (3) CHANGES IN REPORTING FORMS; AND (4) CONFIDENTIALITY CONCERNING THE PROS.

FURTHER, AS PART OF OUR STUDY, PHYSICIANS AND OTHER MEDICAL STAFF FROM OUR OFFICE REVIEWED INDIVIDUAL PATIENT RECORDS. WHILE THEY AGREED IN GENERAL WITH PRO FINDINGS ON THE TYPES AND SEVERITY OF THE QUALITY CONCERNS, THEY DISAGREED WITH THE APPROPRIATENESS OF THE ACTION(S) TAKEN BY THE PRO IN 79 PERCENT OF THE CASES. RATHER WE FOUND THAT A NUMBER OF THESE CASES INVOLVED A GROSS OR FLAGRANT VIOLATION AND SHOULD HAVE BEEN REFERRED FOR SANCTIONING.

WE HAVE SENT THESE CASES BACK TO THE PROS WITH REQUESTS THAT THEY CONDUCT REVIEWS TO DETERMINE IF SANCTIONS SHOULD BE RECOMMENDED. WE AWAIT THE FINAL RESULTS OF THESE REVIEWS.

WE ARE PLEASED TO SAY THAT, BASED ON OUR FINDINGS, HCFA ISSUED FURTHER CLARIFYING INSTRUCTIONS IN JULY 1985. THESE INSTRUCTIONS HAVE GREATLY REDUCED THE PROBLEM. HOWEVER, TO DATE, ONLY 30 PROPOSED SANCTIONS HAVE BEEN REVIEWED BY THE OFFICE OF INSPECTOR GENERAL FROM ONLY 9 PROs. OUR OFFICE IS WORKING CLOSELY WITH HCFA, THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION AND INDIVIDUAL PROs TO STRENGTHEN THESE SANCTION PROCEDURES.

WE ARE NOW IN THE PROCESS OF CONDUCTING ADDITIONAL WORK TO ASSIST IN DEFINING THE NATURE AND EXTENT OF THE PROBLEM OF POOR QUALITY OF CARE. OUR OFFICE IS CONDUCTING AN EXTENSIVE REVIEW OF 30 MEDICAL RECORDS PER HOSPITAL IN A RANDOMLY SELECTED SET OF 240 HOSPITALS UNDER PPS. WE ARE LOOKING AT MANY ISSUES IN THIS STUDY, INCLUDING APPROPRIATENESS OF ADMISSIONS, QUALITY OF CARE DURING THE HOSPITAL STAY, AND WHETHER THE DIAGNOSTIC RELATED GROUP (DRG) ASSIGNED FOR PAYMENT PURPOSES WAS CORRECT. IN A SEPARATE REVIEW TO BE CONDUCTED THIS FALL, WE WILL PERFORM A FOLLOW-UP STUDY TO DETERMINE IF PRO HAVE CORRECTED THE SYSTEMS AND PROCEDURAL WEAKNESSES THAT I HAVE DESCRIBED IN DETAIL THIS MORNING. WE WOULD BE HAPPY TO INFORM YOU OF THE RESULTS OF THESE STUDIES AS SOON AS THEY ARE AVAILABLE.

IN CONCLUSION, LET ME SAY THAT WE ARE COMMITTED TO ASSURING THROUGH OUR REVIEW WORK AND OUR SANCTIONS PROGRAM THAT EVERY MEDICARE BENEFICIARY RECEIVES THE HIGHEST QUALITY OF CARE POSSIBLE.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

INSPECTION OF
INAPPROPRIATE DISCHARGES AND TRANSFERS

(Major Findings)

RICHARD P. KUSSEROW
INSPECTOR GENERAL

Full Report Available from:

Office of Analysis & Inspections
Region V
300 So. Wacker Drive
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Chicago, IL 60606

March, 1986

OAI# P-05-86-00050

MAJOR FINDINGS

- Based on the findings of this inspection, it is apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by the Health Care Financing Administration (HCFA) and the Peer Review Organizations (PROs).

- During 10/1/83 - 5/31/85, HCFA reported 4,724 cases of premature discharges and inappropriate transfers. Yet, only 2,688 (57%) of the reported cases could actually be found. This is due to the phasing out of the Medical Review Entities (MREs), inconsistent instructions given by HCFA, and inaccurate reporting by the PROs. Another 1,018 cases were reviewed, of which 282 were reported after 5/31/85 and 736 had never been reported (See chart on page 9.) Also, during the time frames mentioned above, 14 (30%) of the PROs were not reporting premature discharges or inappropriate transfers. Therefore, the overall extent of the problem is still not fully known.

- Of the 3,706 cases reviewed, 3,336 (90%) were referred by the PROs; 370 (10%) were referred prior to PRO implementation. One hundred and fifty-seven (4%) of the 3,706 cases were not inappropriate discharges or transfers. Of the remaining 3,549 cases, 2,907 (82%) were premature discharges, 491 (14%) were inappropriate transfers, and 151 (4%) could not be categorized by type.

- Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 2,146 (60%) of the 3,549 cases. PRO disposition of these cases ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 927 (43%) of the cases with identified quality issues the only apparent action taken by the PRO was referral to HCFA.

- Of the cases reviewed, medical records involving 133 patients were referred to OIG physician consultants for review. Nineteen were classified by OIG consultants as exhibiting gross and flagrant instances of substandard care. PROs took no corrective action, other than referral to HCFA, on 12 of these 19 cases. In the opinion of the OIG medical consultants, inappropriate actions were taken on 106 of the 133 cases. Thirty-eight of these cases have been returned directly to the PROs for various recommended actions. The remaining cases are currently being reviewed by HCFA.

- PROs did have the authority to take action on the quality issues identified in this study. It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges and inappropriate transfers.

- During OIG site visits conducted in September and December, 1985, problems were noted with the PRO's accumulation of data pertaining to the quality of care rendered by physicians and hospitals. This data is necessary for the identification of abusive patterns and subsequent corrective action.

- HCFA has reviewed the recommendations contained in this report and concurs. It has already begun to correct a number of problems identified in the inspection. Details regarding HCFA's actions can be found in the appendix attached to this report. Also, increased sanction activity by the PROs against physicians/providers demonstrating abusive patterns of practice has been recently noted.

AAHA

STATEMENT

by the

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

for the

COMMITTEE ON FINANCE

U.S. SENATE

June 17, 1986

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
1129 20th Street, NW, Suite 400, Washington, DC 20036 202 · 296 · 5960

Mr. Chairman and members of the Committee, the American Association of Homes for the Aging (AAHA) appreciates the opportunity to submit testimony on S. 2331, The Medicare Quality Protection Act of 1986. We commend your efforts to maintain quality in the Medicare program at a time when concern for budget deficit reductions threatens to undermine the integrity of this health care program for the elderly.

Many of the provisions of S. 2331 will directly affect the members of our association. Those members represent approximately 2,800 nonprofit facilities which provide housing, health care, and community services daily to more than 500,000 elderly individuals nationwide. Over 75 percent of AAHA members are affiliated with religious organizations. The remaining members are sponsored by private foundations, government agencies, unions, fraternal organizations, and community groups.

AAHA strongly supports the sections of this bill which would promote quality hospital and post-hospital care and enhance access by Medicare patients to long term care, when that care is necessary. We particularly support provisions which would discourage premature hospital discharge and which would require discharge planning as a condition of participation. We believe that both of these provisions would increase the likelihood that patients are stabilized before leaving the acute care hospital setting. We also believe these provisions would lessen the unpredictability of post-hospital placements for both the beneficiaries and the providers of post-hospital care.

In addition, AAHA believes that there are several proposals in S. 2331 which present enormous potential to further the quality goals of this legislation. We would like to comment on these provisions specifically, with some suggestions for clarification and/or extension of the ideas set forth.

1. The Study of Administratively Necessary Days

AAHA supports Section 106 of the bill which would require the Secretary of the Department of Health and Human Services to study the reinstitution of separate payments for administratively necessary days (ANDs). We particularly endorse the requirements that the Secretary consider the impact of shortages of post-hospital skilled nursing beds, the risk of discharge to inappropriate institutions, and the administrative mechanisms which can be used to prevent inappropriate payments for ANDs.

AAHA does not support the implementation of separate payments for ANDs without further study, because we believe that such a plan would perpetuate a short-term solution to what has become, and will continue to be, a chronic problem in long term care. There remain too many "unknowns" to justify the implementation of separate payments without a deeper understanding of the problem they purport to alleviate.

The concept of administratively necessary days is similar in some ways to that of swing beds. Both plans reimburse hospitals for providing long term care to patients for whom acute care is not needed but for whom skilled nursing beds are unavailable. The swing bed program assists small rural hospitals; the ANDs approach does not list specific criteria for a hospital's participation.

For either the swing bed or AND approach to operate, two economic forces must be present: 1) there must be at least a temporary shortage of skilled nursing beds, and 2) there must exist hospitals with low occupancy rates. The existence of both forces in the current marketplace has been well-documented. Although proponents of swing bed/ANDs reimbursement mechanisms tend to focus on the SNF bed shortage part of the equation, the other, inescapable, implication of these reimbursement approaches is that many hospitals, particularly those in small communities, are having severe financial problems and require some type of federal assistance.

This assistance is not in itself objectionable and, in fact, is a positive development in many cases. No organization with Medicare beneficiary interests at heart would advocate a modification in the reimbursement system which undermined the role of the community hospital. The community hospital is, after all, the source of acute care for many of our elderly, as well as the rest of our population. Moreover, the community hospital is frequently the resource on which long term care facilities rely when their residents become acutely ill.

However, while we can support swing bed/AND measures as a short-term, stop-gap means to compensate for the shortage of skilled nursing beds, we part company with proponents of these measures who view them as long range solutions. At some point in the very near future, hospitals must find more appropriate ways to deal with their budget problems, and legislators must accept the need for construction of additional skilled nursing facilities. This will entail the revamping of a regulatory scheme which has systematically erected barriers to the construction of new facilities, such as severe Certificate of Need restrictions. This is not an easy task, but to do less is to send a message to the elderly of this country that we consider the benefits to hospitals to be more important than the costs to patients.

The patient "costs" we refer to are real and have several dimensions. Initially, research findings presented at a recent swing bed conference sponsored by the Robert Wood Johnson Foundation indicated that although long term care provided by hospitals is cheaper for short stays, the care becomes more expensive over time, if compared with the cost of nursing home services. Second, the type of geriatric functional assessment required to understand an individual's long term care needs is not generally completed by physicians and nurses in acute care settings. As a result, the individual attention needed to preserve an elderly person's independence (to the extent possible) may be sacrificed to the regimen necessary for the efficient management of an acute care hospital. Third, quality of life concerns for most residents (food, staff attitudes, activities, access to outside visitors, etc.), are not those best met in a highly technical, acute care setting.[1] There is nothing to indicate that the experiences of swing beds and ANDs would be different.

Our concerns over the potential for extensive lengths of stay under the AND mechanism are based on the following relevant facts: 1) hospital occupancy rates are continuing to decline and this trend shows no tendency to reverse itself; 2) many states now have a moritorium on nursing home bed construction, and pressures to keep Medicaid spending under control make it unlikely that those moritoria will be lifted anytime in the near future; and 3) according to 1983 U.S. Bureau of Census projections, the actual numbers of elderly will continue to rise rapidly. Between the years 1980 and 2000 (just 14 years from now), the number of elderly 85 years and older will more than double from 2,240,000 to 5,136,000.[2] This age group has the highest nursing home utilization rates of any group in our population.

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[1] Swing-Beds: "Experience and Future Directions," sponsored by the Robert Wood Johnson Foundation and held at the Brookings Institution, February 24, 1986. Proceeding will be published in late summer, 1986.

AAHA's concern is that these factors will come together with the "kill two birds with one stone" philosophy and point the way to long term residence of the elderly in acute care hosptials, facilities which are not equipped, or disposed, to meet the needs of the institutionalized aged.

We raise these points in connection with the proposed study because we believe that the time to start dealing with this issue is before it hits crisis proportions. The way to approach the issue is to develop a body of information which will define the parameters of the problems, identify possible solutions, and remove the barriers to those solutions. We have come to the point where anecdotes are no longer acceptable substitutes for data. We are also at a stage where any study which manages to be funded and conducted should be developed to yield the greatest amount of information possible.

AAHA believes that the proposed study of ANDs is a strong vehicle to begin gathering the information we need to plan for the long term needs of our growing elderly population. Specifically, we encourage the Committee to broaden the scope of the study to look at the methods hospitals use to identify the availability of alternative long term care services before relying on ANDs; to develop at least minimum standards and guidelines for documentation of the unavailability of skilled nursing beds; to identify the average length of stays in acute care hospitals which are characterized as administratively necessary days; to determine the number of patients and hospitals involved; to identify the geographic fluctuation (both by region and urban/rural) in AND utilization; to ascertain patterns, if any, of specific DRG classifications which appear to require ANDs; and to establish the degree to which the use of ANDs provides evidence of a short-term or chronic shortage of skilled long term care beds.

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[2] Cited in "Health Care Needs of the Elderly," by Dorothy P. Rice, appearing in Long Term Care of the Elderly, Harrington, Charlene, et. al, eds., Sage Publications, Beverly Hills, California (1985).

Additionally, AAHA recommends that the language of Section 106 (c)(1)(A), "Considerations in Conducting Study", be clarified. As now constructed, that section reads:

> [the Secretary shall consider the need for such a payment in order to minimize]
>
> (A) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care.... (Emphasis added.)

We were unable to determine the meaning of the underlined phrase or its relationship to the rest of the paragraph.

2. Extension of the Waiver of Liability

AAHA appreciates the bill's proposals to strengthen the waiver of liability for both skilled nursing facilities and home health agencies. We strongly support the provision which states that if SNFs or HHAs request a reconsideration of a denied claim, the favorable presumption would remain in effect pending the outcome of an expedited review determination. Similarly, we favor the provision which would permit providers to appeal adverse coverage decisions on behalf of beneficiaries.

In addition, AAHA agrees that the waiver should be extended to cover HHA technical denials. However, we believe, that to have meaning, the new HHA waiver provisions should be accompanied by a return to the five percent claims denial threshold, rather than the 2.5 percent threshold under current law. If the 2.5 percent threshold remains, increasing the categories of claims which can be counted against the waiver will result in HHA waivers being lost more readily. The enhanced predictability of claims approval which S. 2331 intends to achieve by this provision would effectively be lost.

A3. Development of a Uniform Needs Assessment Instrument

AAHA supports a uniform needs assessment instrument as a worthy goal but encourages the Committee to recognize past experience in this area. One of the most recent attempts to develop such a document was the PACE project, which resulted in a 40-page form. Use of the form never became a requirement because by the end of its development, it was generally considered unworkable.

In addition to past difficulties involved with this type of instrument, AAHA believes clarification is necessary regarding part (a)(1)(C) of Section 204.

That section now reads:

> [The Secretary shall develop a uniform need assessment instrument that...evaluates]
>
> (C) the social and familial resources available to the individual to meet those requirements;

Currently, this language is not in the law which sets out criteria for determining whether skilled nursing care is needed and reimbursable. Section 1814 of the Social Security Act provides that Medicare will make payment for services that—

> (B) in the case of post hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care...which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis....

It is unclear whether the proposed language sets out new criteria for evaluating the need for SNF care or is intended to amplify the "practical matter" requirement. AAHA believes that this language has the potential to be a positive step in recognizing the factors which contribute to the need for post-hospital care. However, we are concerned that the language could also be turned around to exclude some elderly from skilled nursing care, even when they meet the qualifications set out in current law.

4. Expand the Role of the Peer Review Organizations (PROs)

AAHA includes under this heading all the bill's provisions to expand PRO review and sanction authority. AAHA is concerned about the expanded role of the PROs for several reasons.

Initially, with reference to Section 320 of the bill (Requiring PRO Review of Quality of Care), we question how "potential problems of quality" will be identified and dealt with in ways which differ from methods already employed by state inspection teams, federal look-behind study teams, and long term care ombudsmen. Besides the fact that these individuals and groups will be falling over each other searching for poor quality, we question whether the PROs traditional orientation to a medical model of review (for use in acute care settings) is the most appropriate review mode for long term care. It appears to us that medical review, supplemented with a long term care perspective, is required of HCFA's new long term care survey process, soon to be implemented by the States. This survey process will include the failure to provide necessary services. AAHA believes that the new patient survey process should be allowed to get underway before another layer of review is added.

With regard to the PROs' new assignment to investigate all written complaints made by beneficiaries or their representatives, we support providing a confidential outlet for beneficiary complaints; however, we are not clear as to how the proposed complaint system will mesh with the ombudsman program under the Older Americans Act. Since it is contemplated that increased funding for PROs would be involved with this expanded scope of work, it might be more economical to put those funds into better training for ombudsmen, rather than to initiate a new, and probably overlapping, investigation system.

5. Study of Long-Term Quality Assurance and Review Strategy

The Association supports this study. Although we recognize that it may overlap with the recent Institute of Medicine effort, AAHA was disappointed that reimbursement was beyond the scope of the IOM study and would welcome any analytical work which will link the IOM findings to reimbursement issues.

The connection between quality and reimbursment has been dismissed by many researchers as "too complicated" to be included within the same study. There is no dispute that the issues are complicated. However, the federal government expects providers and beneficiaries to deal with these complications every day in situations which are a great deal less dispassionate than the research setting. AAHA thanks the sponsors of S. 2331 for seeking to have the Department of Health and Human Services address this difficult but essential issue.

In closing, we want to reiterate the Association's appreciation for the efforts to uphold the quality of the Medicare program. S. 2331 clearly reflects an approach which seeks to address some frustrating provider issues, while maintaining a sensitivity to the needs of this country's 32 million Medicare beneficiaries. AAHA looks forward to working with the Committee as the bill proceeds through the legislative process.

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TESTIMONY OF

JOHN P. PAPP, M.D., FACG
PRESIDENT
OF
THE AMERICAN COLLEGE OF GASTROENTEROLOGY

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

PROSPECTIVE PAYMENT SYSTEM
AND
QUALITY HEALTH CARE

JUNE 3, 1986

Annual Scientific Meeting and Postgraduate Course
October 15-19, 1986, Atlanta Hilton Hotel, Atlanta, Georgia

Mr. Chairman, and Members of the Committee on Finance, the American College of Gastroenterology (ACG) is pleased to present testimony concerning the Prospective Payment System and quality of care.

Federal health policy is causing deterioration in the quality of health care being delivered in this country. The current national obsession with cost containment and the implementation of the Prospective Payment System (PPS) are factors responsible in great part for the decline.

It is generally agreed that the PPS provides incentive for a rapid discharge from the hospital. Large numbers of not-fully-recovered Medicare patients in need of sub-acute medical attention are being released from hospitals into their communites for care. Our nation's health care system is not designed to handle such medical needs. We are experiencing a profound shift in the demands on the health care delivery system, caused by the PPS, and few, if any medical communities are prepared for this change. Long-term care providers do not have the resources necessary to "gear up" to meet sub-acute care needs of the discharged Medicare patients. There are simply not enough facilities. This problem is further exacerbated by current federal policy and restrictions that discourage development of new long-term care facilities. Some would respond to that statement by saying that Homecare is more readily available to patients discharged from hospitals after a PPS stay. ACG concurs with this, but also would like to warn that Homecare in many cases is not an adequate substitute for nursing home care, a perception we are afraid that many cost conscious policy makers would like to believe. Allow me to also mention that because of the lack of intermediate sub-acute care facilities available in many areas, some Medicare patients, who are ready for hospital discharge but not well enough for Homecare, are kept at the hospital, at the hospital's expense, additional days while a "precious and few" nursing home bed is secured.

Many physicians find themselves in a similar situation. Most gastrointestinal patients have complex and unique health care needs that require thorough examinations and continuous follow-up. But the Diagnostic Related Groups of the PPS, and Medicare in general does not allow for this emphasis. Instead, there is a push by Medicare and Health Care Financing Administration decision makers to discourage thorough medical gastrointestinal examinations, GI patient nutrition and diet monitoring, and conscientious patient follow up. An indication of this may be HCFA's current efforts to get elderly beneficiaries signed up with HMO's that have traditionally been geared toward providing care for healthy young people.

Finally, Mr. Chairman, I must emphasize that while current federal policy is to ratchet down on health care benefits to the elderly, America's average person isn't getting any younger.

Within the next twenty years there will be more elderly persons than ever before. Our nation's leaders had better take a new look at our already inadequate system of providing medical care for aged individuals. Instead of nickle and diming the system to the bone, Congress and the Administration should be examining the best way to expand and improve our ability to care for the nations elderly population.

Thank you for the opportunity to present the views of the American College of Gastroenterology.

American
Diabetes
Association, Inc.

National Service Center [illegible] Duke Street Alexandria, Virginia 22314 [illegible]

STATEMENT

of the

AMERICAN DIABETES ASSOCIATION

to the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

on the

QUALITY OF CARE UNDER MEDICARE PROSPECTIVE PAYMENT

June 3, 1986

Officers
[illegible]

The financial impact of diabetes mellitus on the Medicare program is considerable. In 1982 the Health Care Financing Administration (HCFA), the financial arm of Medicare, compiled data on the costs of hospital care for patients with different discharge diagnoses. Although the majority of elderly people with diabetes are hospitalized for cardiovascular disease or for complications of diabetes rather than for diabetes mellitus per se, the "Medpar" file for fiscal year 1982 (based on a 20% sample of Medicare discharges) indicated that uncomplicated diabetes mellitus was the ninth leading discharge diagnosis, with a projected cost of more than $288 million per year for hospital care.

In early 1983 Congress passed legislation (1) creating the Medicare Prospective Payment System (PPS), which has replaced cost reimbursement payments to hospitals for the inpatient care of Medicare beneficiaries. Inasmuch as the intent of the law is to control the escalating costs of hospitalizations, it is not surprising that the HCFA has paid special attention to "uncomplicated" diabetes mellitus and a number of other diagnoses for which hospital admission rather than outpatient care might be construed as unnecessary.

Review of the appropriateness of hospital admissions is the responsibility of Professional Review Organizations (PROs) under contract with the HCFA. If an admission does not meet criteria agreed on in the contract between a PRO and the HCFA, the PRO is supposed to instruct the Medicare fiscal intermediary (often an insurance company) not to pay the hospital for that admission. The "principal admission diagnosis" is identified by the medical records personnel of each hospital, who use numerical codes listed in the International Classification of Diseases (ICD), a manual designed for recording mortality and morbidity statistics. The ICD is revised every 10 years under the auspices of the World Health Organization; the US version is the ICD-9-CM (clinical modification).(2)

The PPS, on the other hand, groups the principal diagnosis of each patient according to 467 different "principal" diagnosis-related groups (DRGs) for purposes of prospective payment (3-5). The Health Systems Management group of the Yale University School of Organization and Management matched DRGs with ICD-9-CM diagnosis codes (6) and provided the HCFA with computer software to give Medicare fiscal intermediaries, which would in turn identify cases for review by PROs. Diagnosis-related groups 294 and 295 embrace the following ICD-9-CM diagnoses for diabetes mellitus: 250.0, without mention of complication; 250.1, with ketoacidosis; 250.2, with hyperosomolar coma; 250.3, with other comas; 250.4 with renal manifestations; 250.5, with opthalmic manifestations; 250.6, with neurologic manifestations; 250.7, with peripheral circulatory disorders; 250.8, with other specified manifestations; 250.9, with unspecified complication. The fifth digit of the code determines whether diabetes was adult-onset or unspecified (0) or juvenile type (1).

Each DRG has a weighting factor (see Table 1), which is multiplied by the "average cost" per case to calculate payment to the hospital. Factors other than DRGs that determine what the cost of the "average case" will be have been outlined extensively in the Federal Register (3-5) and in several comprehensive commentaries (7-9).

After the proposed PPS regulations were published on September 1, 1983, (to be implemented on October 1) (5), the American Diabetes Association (ADA) transmitted some misgivings to the HCFA (10). The first of two important concerns was that there might be a financial disincentive for ancillary services, such as patient education, which is so important for diabetes. The customary Medicare part A cost centers for such services would be removed by PPS and not replaced by incentives for outpatient care. Although there does not appear to have been any systematic review of the effects of the PPS on the spectrum of hospital ancillary services, a letter was sent from each of the 10 regional offices of the HCFA to all Medicare fiscal intermediaries in 1984 stating that outpatient education of diabetic patients is a reimbursable service under Medicare part A. Whether more than a few patient education programs have been able to take advantage of this instruction is uncertain, inasmuch as the policy appears not to have been implemented by most Medicare programs.

The second of ADA's two main concerns was that the cost and length of stay of diabetes DRGs 294 and 295 (Table 1) had been underestimated and that the impact of diabetes as a comorbid factor on the cost of other DRGs might also have been underestimated. Anticipated effects would include premature discharge of patients with diabetes or difficulty in obtaining hospitalization.

This report is the result of an effort by the ADA Government Relations Committee to discover whether the PPS was having such deleterious effects on the quality of care of people with diabetes. It was accepted by the committee at its October 1985 meeting.

The impact of PPS on the hospitalization of diabetic individuals has been difficult to assess. Two potential sources of information exist: the Health Care Financing Administration (HCFA) and the PROs in 53 different geographic areas. The objectives of the PROs, stipulated in their contracts with Medicare, fall into two categories: 1) Admission-reduce inappropriate admissions, reduce admissions for procedures usually performed on an outpatient basis, reduce admissions for unnecessary invasive procedures, reduce inappropriate transfers to hospitals not covered by the PPS, and monitor admission patterns; and 2) Quality of Care-reduce readmissions resulting from inadequate care during previous admissions, ensure the provision of medical services that, by omission, can cause patient complications, reduce avoidable deaths, reduce unnecessary surgery and invasive procedures, and reduce avoidable postoperative complications.

METHODS

Information as to the appropriateness of hospital admissions and the quality of care had to be elicited from the PROs. A letter was sent from the ADA to each PRO inquiring how DRGs 294 and 295 were reviewed, whether there had been any significant number of denials of admissions or of payment for prior admissions of patients with these principal diagnoses, or whether there had been problems related to other DRGs in the case of a diabetic patient. Answers were obtained through written replies or, failing that, inquiry by telephone from all PROs except those in US territories that are currently exempt from the PPS. The PROs in four states not subject to the federal PPS (Massachusetts, Maryland, New York, and New Jersey) were nonetheless conducting retrospective review. Their answers are included.

RESULTS

Table 1 lists the relative weights for reimbursement of DRGs by the HCFA. The downward revision for DRG 294 and the increase for DRG 295 (5) imply answers to ADA's question of whether the costs of hospitalization had been underestimated. According to the HCFA the cost of hospitalization of patients 36 yrs. old with the principal diagnosis of diabetes must have been overestimated in 1983, whereas the cost of care for younger diabetic patients (very few are covered by Medicare) had been underestimated. The new data base used by the HCFA for the 1985 relative weights was derived from 100% of Medicare discharges in fiscal year 1984 and the sources of data were the fiscal intermediaries in each geographical area.

The answers to our inquiries suggest that information on inappropriate hospital admissions is unreliable and the information on which HCFA based its revised factors for payment is incomplete. One problem is a lack of uniformity in the determination of the appropriateness of an admission by PROs. Table 2 shows the great variation in what different PROs review. A few PROs have been carrying out preadmission approval as one of the specified objectives in their contracts with the HCFA. The majority however have been doing retrospective prepayment review of ICD-9-CM (2) discharge codes 250.00 (non-insulin dependent, uncomplicated diabetes mellitus) and 250.01 (insulin dependent, uncomplicated diabetes mellitus). When Medicare fiscal intermediaries encounter these codes, their computer software should identify such cases by means of the "Medicare Code Editor" computer program and call them to the attention of the PRO. With no guidelines from the HCFA, it has been up to PROs to select and implement their own screening criteria based on appropriateness of an admission. Most have adopted ISD^{R} criteria, marketed by Interqual, a consulting firm in Chicago, IL. (Tables 3 and 4). If a case fails to meet the criteria for an appropriate admission, decisions as to denial of payment are usually made by physician consultants.

A few PROs were unwilling or unable to provide information on denials. A number stated that there were "no problems", "very few cases", or "no denials". In short, with a few exceptions (e.g., the PROs in Oklahoma, New Hampshire, and South Carolina) the PROs were not able to provide adequate answers, in part because of the second problem: the computer programs (the Medicare Code Editor, etc.) used by fiscal intermediaries have seriously underestimated the number of cases with DRGs 294 and 295 or ICD-9-CM codes 250.00 and 205.01. Some of the problem can be attributed to mismatches between the etiologic orientation of ICD-9-CM discharge codes and DRGs. Mullin (11) has recently reviewed the difficulties inherent in matching ICD-9-CM discharge codes and DRGs. One example, which has already been recognized and will be remedied (5), is that diabetic individuals who have kidney transplants have been assigned to DRG 468 rather than 302 (see Table 1). What is more important is that cases are being lost altogether by fiscal intermediaries (e.g., as noted in Florida, Georgia, Nebraska, and New Jersey). The staffs of most PROs appear to be under the impression that very few cases of uncomplicated diabetes are hospitalized, e.g., statements that "only 10 cases" (Kansas), "very few cases" (Maine, Virginia), or "no cases" (Nebraska, District of Columbia) of uncomplicated diabetes were identified. However, the experience of the PRO in South Carolina, a state with less than 2.5 million in population (2307 cases of DRG 294 and 45 cases of DRG 295 identified in fiscal year 1983), is much more consistent with the large number of cases collected by the HCFA in its 1982 Medpar file before the current system(s) for data collection was implemented. As a result, many cases assigned 250 ICD-9-CM codes are not being properly allocated to DRG 294 or 295. As some PRO staff have suggested in telephone interviews, there may be general problems with the Medicare Code Editor computer software that extend beyond diabetes DRGs. The present system of information retrieval may thus prevent accurate assessment of the cost of hospitalization of other DRGs as well.

There are no data relevant to the quality of care of diabetic patients covered by DRGS 294 and 295. The reason is straightforward. PRO appears to consider discharge criteria (e.g., those proposed by Interqual, Table 4). Despite the statement that PROs "have under contract with the HCFA responsibility for evaluating whether the quality of services meets professionally recognized standards of health care" (5) only two have been reviewing the quality of care of patients with diabetes. West Virginia PRO has been monitoring readmissions of patients with DRG 294, noting that more than 30% were admitted twice during fiscal year 1983; the California PRO is monitoring the occurrence of complications in patients with ICD-9-CM discharge codes 250.1-250.9.

CONCULSIONS

The validity of the data that the HCFA used to revise the relative weights of DRGs 294 and 295 (Table 1) is questionable.

Our attempt to discover if the PPS would have an adverse effect on the quality of diabetes care failed because of problems inherent in the PPS. Even the negotiation of contracts between the HCFA and PROs has been difficult. The results of our inquiry suggest that the contracts have not been supported either by adequate guidelines for PRO review or measures of PRO performance. The confused picture of the relatively narrow area of diabetes mellitus may be representative of a more global dilemma of the HCFA and PRO groups: They had to implement their reviewing activities without enough time to plan adequately, to publish adequate (proposed) regulations for PROs, or to test the adequacy of their data retrieval system. Analysis and repair of the deficiencies of the PPS should be Medicare priorities, certainly before the even more complicated possibility of payments to physicians for in-hospital care (MD-DRGs) is considered as an addition to the PPS (12).

The information in this report has recently (October 1985) been presented to the ADA Government Relations Committee. The committee has accepted this report and will consider various strategies in addressing ADA's concerns (10) about the impact of the PPS on quality of care. It may be possible to exert some influence on the HCFA to 1) provide new instructions and guidance to curtail the variations in PRO practice. (Unless this is done, data from different PROs will not be comparable and it will be impossible to assess the effects of intervention by PROs except on a state-by-state basis.); 2) improve the data collection system and eliminate coding mismatches, which not only prevent reliable analysis of fiscal data but of quality of care as well; 3) implement quality-of-care review by PROs. (This activity has been neglected by PROs because the quality of care has not been an explicit contract objective and because there are virtually no guidelines for such review.)

Additional legislation may be necessary if HCFA is to attend to this problem. Congressman Roybal of California, chairman of the congressional Select Committee on Aging, introduced a bill (HR1970) early in the current congressional session "The Quality Assurance Reform Act of 1985" which would require that as of October 1, 1986, one half of a PRO's efforts be towards quality review. It would also establish a National Council on Quality Assurance to recommend improvements to HHS and Congress and would instruct the Department of Health and Human Services to conduct studies on the impact of the PPS on the quality of care. Although this specific legislation does not seem to have progressed in committee, simlar legislation may be important because attention to the quality of care may be the only effective protection against any detrimental side effects of cutting the costs of hospital care.

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TABLE 1

SOME DRGs RELEVANT TO DIABETES MELLITUS

DRG	TITLE	RELATIVE WEIGHT	DAYS IN HOSPITAL (LOS)	OUTLIER CUTOFFS (DAYS)
294	Diabetes, age >36 yr	0.8087 (0.7636)	7.7 (5.6)	28 (24)
295	Diabetes <0-35	0.7457 (0.8251)	5.6 (5.1)	26 (22)
23	Nontraumatic Stupor, Coma	1.1568 (1.1319)	5.9 (5.2)	26 (22)
285	Amputations for... metabolic disorders	2.8658 (2.6869)	24.0 (18)	44 (32)
287	Skin grafts and wound debridement for...metabolic disorders	2.8143 (2.2793	22.8 (15.2)	43 (35)
320	Kidney-urinary track infections and c.c.	0.8123 (0.8596)	7.0 (6.5)	27 (23)
302	Kidney transplant	6.6322	24.1	44
468	Unrelated OR Procedure	2.1037	11.2	31

* DRG assignments have been summarized in Federal Register publications by the HCFA of interim final (3) final (4) and 1985 proposed rules (5). For each acute care hospital covered by PPS, there is an index dollar amount for the average case which is then multiplied by the relative weights assigned to each DRG in 1983. Revised relative weights, etc., which were to take effect on October 1, 1985, are given in parentheses. The geometric mean of length of stay provides some of the data re intensity of care, leading to the assignment of relative weights, and is a guideline for review by PROs. Outlier cutoffs are the thresholds (there is a cost threshold also) that must be exceeded for extraordinary reimbursement by Medicare to be considered.

TABLE 2: PRO Review of cases of uncomplicated diabetes mellitus

Function	States
Preadmission Approval	
All elective admissions	AL, KY, TN, WI
All medical admissions	MN
DRGs 294 and 295	NJ, AZ, HI, DE
DRG 294 only	ND, WV
Retrospective prepayment review	
DRGs 294 and 295	ID, IN, IA, OR, SC
DRG 294 only	CO, MD
ICD-9-CM 250.00 and 250.01	AK, AZ, AR, CA, CT, DE, DC, FL, GA, HI, IL, KS, LA, ME, MD, MA, MO, MT, NB, NV, NH, NJ, NY, OH, OK, PA, RI, SD, TX, UT, VA, WA, WI
ICD-9-CM all 250 codes	MS
None	NM

*Review for preadmission approval is carried out by a few PROs that have explicit objectives in their contracts with the HCFA for reducing the number of admissions of specific DRGs. Retrospective prepayment review is carried out according to instructions given in PSRO Directive 107 from the HCFA (1983), which requires review of 100% of cases with certain DRGs, 294 and 295 among them. Most PROs rely on the discovery of the counterpart ICD-9-CM hospital discharge codes by the Medicare fiscal intermediaries in their locality.

Table 3: Screening criteria for retrospective payment* of DRG 294 and 295 hospitalizations

Criteria	No. of PROs
Detailed local criteria	7
Rudimentary local criteria	5
Interqual-ISD or minor modification	17
Dr. Paul Gertman's AEP-SIIS Criteria	2
"Validation" criteria of the AMA	2
Not stated	8
Total	41*

*Several PROs that carry out preadmission approval also carry out retrospective review.

Table 4: Synopsis of Interqual screening ISD criteria for DRGs 294 and 295

Appropriateness of Admission

Severity	Intensity
Wide variations in BS	Special care unit
BS <50 or >300 mg/dl	Intravenous therapy
New patient: FBS > 250	Initial insulin therapy
Acetone in blood	Insulin pump regulation
Blood pH < 7.35	Newly diagnosed pregnant
Acetone in urine	
Urine > 3+ S	

Appropriateness of discharge

No change in insulin for 2 days	Urine acetone negative
BS normal for 2 days	Patient or other administers insulin

STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON THE QUALITY OF CARE
UNDER
MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

TESTIMONY SUBMITTED
FOR THE RECORD

SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

JUNE 3, 1986

The American Psychiatric Association, a medical specialty society representing 32,000 physicians nationwide, is pleased to submit testimony for the record on Quality of Care under the Medicare Prospective Payment System. Our comments focus on the quality of mental health care for Medicare beneficiaries and on S. 2331 (The Medicare Quality Protection Act).

Quality of Mental Health Care

The health care problems of the elderly are often more complex than those of other segments of the population. As the elderly population grows to approximately one in five persons in the next thirty years, we are very concerned, that the 15 to 20 percent -- between 3 and 5 million -- of our nation's more than 25 million elderly Americans who have significant mental health problems are denied adequate treatment because of the discriminatory "caps" imposed on psychiatric treatment under Medicare.

As prospective payment has been phased in, other components of the health care system have transferred care to the outpatient sector. This is not often possible for mental health service delivery. Under the current Medicare system, outpatient benefits are restricted to $250 per year after copayment and deductibles. Because this benefit has not changed since the 1960's, one would need a 1986 benefit of $1100 to have equivalent purchasing power (in constant dollars, the benefit is worth $56.78 today).

When the Prospective Payment System (PPS) was first introduced, APA supported the exemption of freestanding psychiatric hospitals from the proposed DRG system, and successfully persuaded the Congress to also exclude distinct-part psychiatric units of general hospitals as the differentiation was a distinction without a difference. We noted that the psychiatric diagnostic groupings contained in the Yale-developed DRG listing were never validated in any setting (at the Yale research team's own admission) and, it was, in the interest of psychiatric patients, critical that psychiatric hospitals and psychiatric units of general hospitals be exempt.

Since that time research conducted by APA on the appropriateness of the DRG classification scheme for psychiatric patients -- and confirmed in numerous other independent analyses -- has demonstrated that DRGs are not adequate as a patient classification system for the mentally ill -- there is substantial inaccuracy in the psychiatric DRGs' prediction of resource use. The inaccuracy could result in inappropriate discharge of patients, and financial risk to hospitals treating the most severe patients. The researchers employed a large hospital discharge data base (over 1.7 million patient records) to study the potential impact of DRG's on psychiatric patients and inpatient psychiatric units in general hospitals (English, Sharfstein, et al. 1986). The study, conducted under the auspices of the APA Task Force on Prospective Payment, confirmed our earlier concerns and justifies continuation of the exclusion.

The limit on inpatient psychiatric treatment (190 day lifetime limit in a psychiatric facility) clearly also discriminates against our elderly mentally ill. Despite the fact that 20 to 30 percent of elderly Americans labelled "Senile" have reversible, treatable conditions, the combined outpatient and inpatient service limitations may not allow these people to achieve more functional status.

Although the costs and benefits of liaison psychiatry have been documented in the literature, hospitals and physicians struggling to keep costs down may avoid this cost-effective service. All the components of these services -- for instance, discussions with family and staff -- are not fully reimbursed under Medicare. A controlled study examined clinical outcomes of a group of elderly patients (age 65 and over) who underwent orthopedic surgery for fractured femurs. Those receiving liaison psychiatric services stayed in the hospital 12 days less than patients who did not receive such services. (A several thousand dollar cost saving by any measuring device). The treatment group was also twice as likely to be discharged home instead of to a nursing home or other health-related institution. Thus, liaison psychiatry services provided clear cost savings by reducing health care utilization in other portions of the health sector.

Additionally, psychiatric symptoms are frequently non-specific and commonly occur in medical, as well as psychiatric disease. There is evidence indicating that having a psychiatric diagnosis is associated with a high risk of medical illness. Also, there are a great many physical illnesses that, upon initial presentation, appear to be nervous and mental disorders.

The research literature fully documents psychiatric illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, carcinoma of the pancreas, hyper-parathyroidism, Wilson's disease, subacute enephalitis, and strokes.

These studies also emphasize the importance of the interrelationship between specific psychiatric symptoms and specific medical diseases. Physicians in practice must continually weigh such psychological factors as personality traits to properly treat rheumatoid arthritis, hypertension,, peptic ulcer, diabetes, ulcerative colitis, allergic skin infection, bronchial asthma, coronary disease and cancer.

Cutbacks in hospital staff or emphasis on early discharge under PPS may not allow patients to receive the full range of services needed for their care and differential diagnosis could be rushed. The discharge of patients in a "quicker and sicker" fashion may not allow appropriate treatment for psychiatric illness on its own or in combination with other medical illness.

The MEDICARE QUALITY PROTECTION ACT OF 1986 (S2331)

The APA supports the goals of the Medicare Quality Protection Act of 1986 introduced by Senator Heinz and other distinguished members of your committee. We are concerned that the bill does not address discrimination against psychiatric services under Medicare. Our detailed comments are listed below:

TITLE I - Section 101. The requirement to have the Secretary of HHS develop and submit to Congress by January 1, 1988 a legislative proposal to refine PPS to better account for variations in severity of illness and case complexity is laudable. We must point out, however, that DRG's may never be the appropriate method for paying for psychiatric services because psychiatric DRG's account for only 3% of the variation in how long psychiatric patients stay in the hospital. In addition, as mentioned previously, the psychiatric DRGs were never validated when originally developed. Some authors have, in fact, suggested that patient characteristics predictive of hospital costs include: degree of disruptivness; degree of disorientation; degree of medical problems; and difficulty of placement. The costs associated with a psychiatric hospital stay include: staff time; length of stay (hotel costs only); charges for diagnostic tests; charges for medical-surgical services and charges for medication. According to these authors, in order to develop a new system for payment, appropriate research would concentrate on developing a scale for clinically assessing patients. (Light et al. 1986).

Section 102 - Mentally disabled persons, who have dementia or other disorders, may, because of their illness need an "advocate" to interpret and assist the to understand and appreciate their discharge rights.

Section 103 - The Section may need amendment so that hospitals may apply for special outlier payments when a beneficiary loses an appeal.

Section 104 - While, in general, we support the prohibition of physician incentive plans, we question how HMO's, which often build into payment, incentives for lower hospital utilization, would be treated in this situation.

Section 105 - Review by the Secretary of quality assurance standards used by hospitals for conditions of participation in Medicare would be appropriate if done in conjunction with the long-established Joint Commission on Accreditation of Hospitals.

Section 106 - A study of administratively necessary days must clearly examine the numbers of our frail, mentally ill elderly who need such care. While those with solely physicial illness may be discharged with appropriate home health care service, the frail, mentally ill elderly may need extra days in the hospital to arrange adequate cost-effective care.

TITLE II- Section 201 - APA supports the provision of appropriate discharge planning. Psychiatrist input (as well as that of other physicians) would be critical in order to develop guidelines and standards for the discharge planning process.

Section 204 - As the Secretary engages in development of a uniform needs assessment instrument, the members of the advisory panel should include a psychiatrist.

Section 207 - As mentioned previously we feel that in many cases a mentally ill beneficiary must have a representative for the appeals process.

TITLE III - Section 305 - APA would be very concerned about sharing of confidential information among PRO's. We have previously testified to the Finance Committee that there is a distinction between treatment notes, and administrative notes by psychiatrists. Treatment notes must be held in strictest confidence -- only for the eyes of the psychiatrists. This section would allow too many people access to very confidential information.

APA recommends that qualified researchers outside the government gather information on the quality of post-hospital care, and develop strategy for long-term assurance and review of quality under PPS. We recommend that the majority of PRO activity emphasize quality of care. In addition, some of the additional PRO activities may not be feasible given current PRO reimbursement. We support the requirement for a consumer representative on PRO boards.

Summary

While APA supports many aspects of S2331, we are concerned that little attention is given to the area of mental health service delivery under

Medicare, and the negative effects on quality of care presented by Medicare's discriminatory coverage policy for mental health services. In addition, we would be very concerned about the maintenance and protection of medical records and treatment notes from unwarranted disclosure during PRO investigations.

We urge that any action on this legislation provide an appropriate response to our nation's more than 25 million older persons who have significant mental health problems, yet are denied adequate treatment because of the discriminatory "caps" imposed in 1965 on psychiatric treatment under Medicare -- where outpatient benefits are restricted to $250 per year after coinsurance and deductibles. Adequate mental health coverage would allow the twenty to thirty percent of older Americans who have been labeled "senile" and actually have reversible, treatable conditions to become productive, active members of society, and avoid unnecessary and costly hospitalization. We have developed pharmacologic and behavioral treatments that are effective in treating phobias and other anxiety disorders, demonstrated that memory loss and other cognitive deficits associated with Alzheimer's Disease may be modifiable with medication; and improved methods for assessing the effectiveness of psychotherapy, and for identifying specific types of psychotherapies best suited to specific disorders. An impressive, but not even an exhaustive list. Medicare coverage policy prevents the elderly from receiving the benefits of these breakthroughs. Improved coverage of the mental health needs of these elderly people under Medicare could provide the mentally ill elderly the dignity, productivity, and independent living to which they are entitled.

apta American Physical Therapy Association

June 5, 1986

The Honorable David Durenberger
Chairman, Health Subcommittee
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Attn: Betty Scott Boom

Dear Chairman Durenberger:

The American Physical Therapy Association is pleased to submit this statement for the record in support of S. 2331, the Medicare Quality Protection Act of 1986. The American Physical Therapy Association represents over 40,000 physical therapists, physical therapist assistants, and physical therapy students. We believe that the Act would provide some valuable safeguards to ensure that our nation's Medicare beneficiaries receive the highest quality services possible both in hospital and in outpatient settings. We would like to offer some brief comments on the provisions of S. 2331 which are of particular relevance to physical therapists and physical therapy patients.

We strongly support the permanent reinstatement of the favorable waiver of liability presumption for home health agencies and skilled nursing facilities. While we are appreciative of the temporary extension of the waiver provisions granted to home health agencies and nursing homes under the Consolidated Omnibus Budget Reconciliation Act of 1985, a permanent extension is necessary. As patients continue to be discharged "sicker and quicker" under the DRG system, the need for skilled nursing, home care, and other types of post-hospital care will continue to increase. While cost-shifting is of obvious concern, it seems a misguided and even perverse remedy to penalize those providers onto whom the burden has been shifted.

The Health Care Financing Administration, in its rule eliminating the waiver, emphasized that major concerns to be addressed are instances in which care is being provided which is not medically reasonable and necessary or which is characterized as custodial care. Yet, despite all assumptions to the contrary, such instances are not universally agreed upon by the intermediaries themselves, nor are they generally known to the providers.

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Most importantly, elimination of the presumption would result in an early curtailment of services to Medicare beneficiaries. Despite the fact that beneficiaries have been found to be in need of more services and a greater intensity of services, providers will be given the clear signal that early termination is the more appropriate course to take.

We are pleased that the legislation proposes to extend waiver of liability coverage to denials based on "homebound" and "intermittent care" requirements. However, we echo the testimony of the National Association for Home Care, which noted before your Subcommittee that the 2.5 percent threshold would need to be adjusted upward in order to account for the addition of these claims into the base used for computation. We request that the level be raised to 5 percent, equivalent to the level of denials allowed for skilled nursing facilities.

We are also pleased that the legislation mandates the Secretary to develop a uniform needs assessment instrument to determine an individual's post-hospital needs. The implementation of the DRG system has fundamentally altered the level of intensity of post-hospital services required for many patients. It is vital that a fresh look be taken at the issue of need and scope of services to be delivered.

We strongly agree with the National Association for Home Care that "probably the biggest problems facing home health agencies at present concern widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted." Many physical therapists own or administer home health agencies and have reported that such delays have greatly increased over the last several months. These small business people cannot afford the long delays which have become the norm in many cases. Further, when coverage decisions are delayed, it forces the provider to choose between continuing to provide services with no certainty that they will ever be reimbursed, or terminating the provision of needed services to the beneficiary.

Finally, we are pleased that S. 2331 would once again allow Medicare beneficiaries to appoint a provider or supplier to represent them in the claims denial process. Our members stand ready and willing to represent Medicare beneficiaries in their appeals, yet the stance of the Health Care Financing Administration precludes this assistance from being accepted. This is especially problematic because it is these very providers and suppliers who could be most effective as the representatives of the beneficiaries in the appeals process. After all, the services denied coverage were rendered by these providers and suppliers. The enactment of S. 2331 would eliminate this major inequity in the current appeals process.

On behalf of our members, the American Physical Therapy Association thanks the Chairman for this opportunity to present our comments.

ASIM TODAY

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE FINANCE COMMITTEE

ON THE

QUALITY OF CARE UNDER MEDICARE PROSPECTIVE PAYMENT

JUNE 3, 1986

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STATEMENT
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SENATE FINANCE COMMITTEE
ON THE
QUALITY OF CARE UNDER MEDICARE PROSPECTIVE PAYMENT

June 3, 1986

The American Society of Internal Medicine (ASIM) is an organization of over 20,000 physicians who specialize in internal medicine, many of whom also practice in a related subspecialty. The Society was founded in 1956 to address socioeconomic issues facing the practice of internal medicine. As the major providers of continuing, comprehensive medical care to adults, internists are especially concerned with the health care of the elderly. ASIM takes this opportunity to express a number of concerns it has with the quality of care beneficiaries receive under the Medicare program. The Society will also take this occasion to voice its support for the Medicare Quality Protection Act as a necessary means for addressing some of the quality problems currently experienced under Medicare.

When the prospective payment system (PPS) was first implemented, ASIM expressed reservations about the effect diagnosis-related groups (DRGs) might have on the quality of patient care under Medicare. Specifically, the Society was concerned that the system could lead hospitals to (1) underprovide services, (2) skimp on care in order to stay within payment limits, (3) artificially inflate diagnoses to obtain higher payments for the hospital (DRG creep), and (4) provide lower quality of care to Medicare beneficiaries.

Because of these concerns, the Society has urged the Secretary of the Department of Health and Human Services (DHHS) to provide greater coordination at the federal level in collecting and disseminating data regarding the quality of patient care. This is necessary in order for Congress and the Administration to properly assess the impact prospective payment has had on patients. In 1984, ASIM wrote to then Secretary of Health and Human Services, Margaret M. Heckler, urging that DHHS, at a minimum, collect data on patient mortality and morbidity and compare prospective payment outcomes with those prior to the current system. In addition, the Society recommended that DHHS:

- Survey (on a confidential basis) physicians, hospitals, and patients periodically to elicit their evaluations of the program's effects on the availability and quality of care;

- Compile and report aggregate data and trends from Peer Review Organizations (PROs) on the number of hospital readmissions resulting from limited care and instances where the underutilization of services may have caused serious patient complications;

- Consider the development of research studies to compare the experiences of states under the national prospective payment program with states operating under a "waiver" from the program;

- Appoint an inter-departmental task force (with representatives, for example, from HCFA, the office of the Secretary, Centers for Disease Control, the National Center for Health Services Research, and/or other appropriate agencies) charged with developing a plan of action to obtain, coordinate and report to Congress and the public all appropriate information on the program's effects on the quality and availability of care.

When Otis R. Bowen, MD, became secretary of DHHS, the Society again wrote to the Department reiterating that a comprehensive program of this sort was necessary to assess and protect the quality of patient care under PPS. The need for such a plan of action has been underscored by the Office of Technology Assessment's (OTA) report titled Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality and Medical Technology. The Society believes that a program coordinated on the federal level is essential for Congress and the Administration to know the full impact of PPS.

ASIM has informally distributed a survey to its members in an effort to gain a better understanding of the positive and negative aspects of the DRG system (Attachment 1). Although this survey is not scientific, it has revealed several troubling problems about the prospective payment system. Most bothersome is the fact that over 200 of the 246 respondents listed specific instances where they believed the quality of care of patients had been harmed by DRGs. The most common concern of members is that physicians are under considerable pressure to make either premature or inappropriate discharges. Another concern mentioned by nearly half of the respondents was that DRGs do not reflect the severity of a patient's illness. As one physician put it, "patients often have several diseases which need evaluation and/or treatment but DRGs relate to only one diagnosis, that means either poor care or cost overruns."

Less than a month ago, ASIM received a letter from a member internist in a rural area that dramatically depicts how serious this dilemma can be. This member is the only internist in his county, and approximately 85% of his practice is comprised of Medicare patients. All of the county is served by one hospital. However, because of financial problems created by DRGs, this hospital may be forced to close. The following quote describes the problems that physicians, hospitals and beneficiaries face under DRGs:

> "The institution of DRGs has very definitely resulted in the need to discharge patients earlier than medically appropriate. As physicians, we now must judge between what we consider to be adequate care of our patients or the financial stability of our hospitals. This has forced us to begin to take chances with inhospital patient care in hope that we can "get by" and then be able to continue what we know is a necessary work-up on an outpatient basis. As a result of this attitude there has been a very definite increase in both mortality and morbidity associated with premature discharges. For instance, an elderly patient that I recently saw in consultation for abdominal pain was discharged

> after an upper G.I. and gallbladder series revealed that he had gallstones. A liver scan was not obtained because we were attempting to save money. The liver scan would have shown hepatic metastatic disease--a disease from which the patient subsequently died. His actual diagnosis became known only after his death. Prior to DRGs a more thorough evaluation would have been done in the hospital, but the government presently does not reimburse us for this. Our efforts at the present time are simply to get the patients over sixty-five out of the hospital as soon as possible without regard for any special problems or even any additional medical problems which they have.
>
> Because of the artificially low reimbursements for medical procedures, as opposed to surgical procedures, elderly patients are being denied adequate medical testing unless their problems appear to be very acute. Patients are therefore being sent home when their acute problems seem to have improved. As a result, they are being readmitted within the next few days or weeks so that further evaluation of their secondary problems can be undertaken. Naturally, with a system such as this, patients become extremely or even critically ill prior to the time of their readmission, further adding to their health problems.
>
> In order for our hospital to have any opportunity at all to avoid bankruptcy, there has been massive short staffing of nurses and laboratory technicians which has resulted in a tremendous increase in the number of laboratory errors, in the number of medication errors and in the complaining of elderly patients that they are not receiving adequate nursing care. I am aware that the DRGs have led to increased cost awareness on the part of the medical staff but feel that we are doing all we can in this regard. The fact of the matter is that the quality of care for our elderly patients has taken a nose dive since the institution of the DRG system and will continue on this sharp fall. "

The ASIM survey further indicates that while the PROs have been established to monitor the patient care provided under Medicare, they have been primarily concerned with restricting hospital utilization rather than with ensuring quality of care. Approximately one quarter of the respondents believe that the PROs had increased the denial rates of medically indicated admissions under DRGs, to the detriment of patient care. Aside from the survey, the Society has received other letters from members who feel quality has been compromised because PROs are denying care that is generally considered appropriate by the medical profession. These members have also felt pressed by the PROs to conduct certain procedures in ambulatory settings when the circumstances indicated that patient care should be done in the hospital setting.

The Society believes this is partially due to the overemphasis on utilization review in the Health Care Financing Administration's Scope of Work for the PRO program. The Society has a long history supporting peer review of patient care that even predates the Medicare program. One of the Society's policies that has evolved from internist-members' experiences in this area is that "high quality medical care deserves precedence over considerations of cost in any peer review program." The Society is concerned that this has not been the case under the PRO program. Although technically HCFA requires PROs to meet certain quality objectives, the overriding emphasis of the program remains on limiting hospital utilization. The Society recognizes the importance of review to reduce unnecessary utilization, and supports such objectives, but it strongly believes that quality review must be the primary purpose of a review program, especially under a prospective payment system. For this reason, the Society has on repeated occasions encouraged HCFA to increase the emphasis on quality under the PRO program.

The ASIM survey is an ongoing project, and the Society has continued to receive mail from members, similar to the letter quoted earlier. Other internists have reported shortages of hospital staffing, elimination of hospital services, such as cancer registries, pressure to upgrade diagnoses, pressure to admit patients on separate occasions when more than one problem exists, and difficulty in getting PRO approval for inpatient care that is necessary or prudent. The Society plans a more scientific survey to further explore the nature of these problems.

These concerns have also been echoed by other agencies and organizations. The American Association of Retired Persons has received hundreds of letters from its membership detailing problems they have encountered under the prospective payment system. The General Accounting Office has also studied this issue and found that (1) patients are being prematurely or inappropriately discharged from hospitals, (2) beneficiaries are confused about their rights and privileges under the present Medicare system, and (3) there is a lack of appropriate post-hospital care for those patients who are discharged from the acute care setting. Findings such as these and others by the OTA, Senate Special Committee on Aging and the U. S. Inspector General have provided further evidence that measures need to be taken to protect the health of Medicare beneficiaries.

In addition, the present emphasis on cost containment under the Medicare program has undermined the physicians' role as patient advocate. On the one hand, through prospective payment and peer review, physicians are expected to limit hospital admissions, medical services and other aspects of health care to that which is strictly medically necessary. On the other hand, physicians are expected to (and should) continue to be the patients' advocate regarding health care. The problem lies in the fact that there often is not a clear medical consensus regarding appropriate health care protocols for treating patients. Therefore, physicians are faced with a choice of providing care they consider to be prudent, and running the risk of having that care retrospectively denied by the PRO, or making difficult determinations that certain services may not be medically essential, and then facing the risk that the care may be deemed of poor quality and, possibly, sanctionable.

Decisions in these gray areas are particularly difficult, given that the paramount concern of any physician is the well-being of his or her patients. There have been instances where patients have not met the PRO criteria for continued hospital care. However, because those patients were not well enough to take care of themselves, did not have an adequate family support system to care for them, or did not have necessary nursing care available, it was not medically advisable to discharge them. In such instances, physicians and their patients are faced with a losing proposition. The physician can either release the patient against his or her best medical judgment or advise the patient to remain in the hospital, knowing that the patient may not have the money to pay for his or her continued hospital care if it is denied by the PRO--care that can cost as much as $800 a day. Both situations are detrimental to patients' physical and mental well-being.

This difficult situation is exacerbated for some physicians who practice at hospitals that keep track of admitting physicians' average case expenses. This can be to the detriment of patients' health care if attending physicians are experiencing direct or indirect pressure from the hospital to keep their hospital expenses in line with other physicians or under a certain cost level. If physicians fear that they will lose their admitting privileges because their cost averages are not in line with other physicians, then they understandably will feel strong pressure to curtail services so that they can continue to care for patients needing hospitalization. On the other hand, if pressure is applied to physicians to limit medical care that is more costly than that provided by other physicians, then the patient can also suffer if his or her physician concludes that his or her freedom to use services that are necessary is limited. Problems such as these make it essential that Congress enact legislation that allows physicians to provide health care that meets their best medical judgment and yet is cost efficient--and that places the proper emphasis on quality under the PRO program.

The Medicare Quality Protection Act

ASIM endorses the Medicare Quality Protection Act sponsored by Senator Heinz and Congressman Stark to address many of the concerns described above. The Society supports this legislation because it will make necessary changes to protect beneficiaries under the DRG system. Specifically, this legislation will:

- enhance the quality of care in the hospital settings;
- provide for better care of patients once they are discharged from the hospital, and;
- enable PROs to better monitor the care by practitioners and providers to ensure that they meet their legal and professional responsibilities.

The Society provides the following comments on several specific provisions in the Heinz-Stark legislation:

- Revise the Prospective Payment System to account for case complexity and severity of illness. ASIM believes the DRG system does not adequately account for different levels of resource consumption that are required for complex or serious illnesses. Each patient's illness is unique to that individual in that it varies in degrees of severity and complexity, depending on a number of factors such as age, general health condition, socioeconomic status, etc. Because each patient's illness is unique, a single diagnosis-related group cannot properly account for every patient's medical needs. In instances where a patient has a complex or serious illness, the hospital may be under extreme pressure to provide the minimum services required in order to limit potential financial losses. Allowances for complexity and severity should help correct this.

- Require the Secretary of DHHS to arrange for a study of hospital quality assurance standards for those facilities participating in Medicare. ASIM believes that a study should be conducted to see if the hospital quality assurance standards are still appropriate under PPS. The Society would further encourage that any findings from such a study be referred to the Joint Commission on Accreditation of Hospitals so that the medical community has input in the revision process.

- Study the necessity and advisability of reimbursing hospitals for administratively necessary days (ANDs). In the DRG survey conducted by ASIM, one of the criticisms leveled by internists was that patients were transferred to inappropriate settings when they where no longer in need of hospital care. Victims of strokes and Alzheimer's disease are two of the types of patients that were mentioned by internists as being particularly susceptible to inappropriate transfers. They may no longer need hospital care but they do need other specialized care that is frequently not available. In such instances the Society believes that it is necessary to provide reimbursement to hospitals so that patients can be appropriately attended to until another appropriate post-acute facility is available. Therefore, ASIM supports a study on administratively necessary days.

- Require hospital discharge planning that is approved by the attending physician. ASIM strongly supports this provision. The Society's internist-members consider this to be one of the major problems confronting Medicare. With DRGs, hospitals have incentives to discharge patients quickly, but not to provide all the necessary planning for a patient to be properly cared for after his or her discharge. Such a requirement would ensure that all beneficiaries receive thorough discharge planning so that their post-hospital care adequately meets their needs. The Society particularly emphasizes the importance of having the physician consulted in the development of the discharge plan so that all of the patients' medical needs can be accounted for before the discharge plan is actually implemented.

- Review hospital readmissions for selected DRGs that occur within 30 days of a discharge. The Society supports this provision as a means of ensuring that patients are not being prematurely discharged. Although the Society supports this provision, we must emphasize that should such a requirement be mandated, additional funding will be needed from Congress so that PROs can properly carry out the additional review functions. ASIM also supports the part of this provision that requires this review for only a few selected DRGs. This will allow PROs to focus on problem areas without spending a large portion of their time reviewing all readmissions occurring within 30 days.

- Expand peer review outside hospital doors. In an effort to address quality issues outside of the hospital setting, the Medicare Quality Protection Act would expand peer review to non-acute care settings, such as HMOs and ambulatory surgical centers. ASIM believes that HCFA should address quality issues in these settings. However, if peer review is to be conducted on outpatient care, then the Society believes that such review should be limited to only those physicians or facilities identified through professionally developed utilization guidelines as potentially aberrant. This would allow PROs to address quality issues without becoming unnecessarily intrusive to the various practice settings.

- Require all PROs to investigate all written complaints of beneficiaries concerning the quality of care they receive. Under an incentive system such as PPS, ASIM believes it is particularly important to investigate quality concerns of Medicare patients. The Society supports the thrust of the bills' provision in this area but believes it needs to be clarified in order to be sufficiently sensitive to the professional reputations of health care practitioners or providers who have in fact provided appropriate, high quality care. First, the Society suggests that the bill be amended so that the PROs would only be required to conduct preliminary investigations of all written complaints. The purpose of this investigation would be to determine whether grounds exist to conclude that "gross and flagrant" violations or "failure in a substantial number of cases" (sanctionable violations under the PRO regulations) may have occurred.

If an incident does not have merit, then the beneficiary should be so informed. However, if a reasonable cause is established that a major quality problem exists, then a full investigation should be pursued by the PRO that includes due process rights for the practitioner--rights that should be specified in the bill. If, after those due process rights have been fulfilled, and a clear Medicare quality problem has been confirmed, then the PRO should take appropriate action, including informing the beneficiary of its findings.

- Require each PRO to spend a reasonable portion of its activities conducting quality review. As mentioned earlier, the Society is concerned that the PROs are not required under the current scope of work to conduct enough review of quality issues. Because of this, the Society firmly supports this provision and would encourage Congress to further define "a reasonable portion" to ensure that quality review is in excess of its current levels.

- Require PROs to share with federally funded quality assurance officials and state protection and advocacy officials information concerning instances of "gross and flagrant" services or "failure in a substantial number of cases" to provide quality care. The Society believes that information regarding incompetent or improper conduct needs to be shared with proper authorities to help assure that only qualified and competent practitioners and providers are able to provide health care. The Society has, in the past, advocated more effective coordination of quality review findings to help ensure that beneficiaries are protected from incompetent providers or practitioners.

The provisions in the Heinz-Stark bill are an important step in helping to assure that quality concerns are made public and properly handled. However, the Society believes that the language in the bill should be further refined to help ensure that the quality concerns are properly handled. The Society believes that information shared with other quality assurance officials should be restricted to cases sanctioned because of "gross and flagrant" care or "failure in a substantial number of cases." The reason for this is because PROs are expected to identify potential quality problems and then investigate them to ascertain whether they are true quality problems. If information is shared with other quality assurance officials before the PRO has fully conducted its investigation, then the professional reputation of the practitioner is put into question without appropriate due process. ASIM believes that this would have two negative effects. First, it would taint the reputation of professionals without due process. Second, it would be likely to discourage physician reviewers from identifying some quality issues if they were afraid that the information would be used by other quality assurance officials before it was fully investigated.

The Society also believes that the information that is shared with state quality assurance officials should be restricted to state licensing boards. The licensing boards are the designated state agencies for determining whether or not a provider or practitioner is competent to provide health care. In making such determinations, the licensing board utilizes a variety of due process procedures to fully determine the competence of the physician or provider in question. If the incompetence of the provider or practitioner is verified, then the state licensing board removes or limits that person or institution's license. In those instances where a case is found to be a result of bonafide incompetence, and the license is removed or restricted, then the citizens within the state are properly protected. This information then automatically becomes public knowledge. Therefore, the bill should direct the PROs to share the information with only those state entities that have the legal authority to restrict practice.

- Require the Secretary of DHHS to study a variety of quality concerns under Medicare. Many of the issues slated for study under this provision of the act are issues that the Society believes need to be studied, as it was pointed out earlier. However, the Society believes that there is sufficient information at this time for the Department of Health and Human Services to begin to implement a more thorough quality assessment program. Specifically, HHS should appoint a task force to develop a plan of action to obtain, coordinate and report to Congress and the public all currently available appropriate information on the effect of PPS on the quality of patient care.

ASIM believes that there are serious quality concerns under the Medicare prospective payment system. As is evident by this statement, ASIM is strongly supportive of the Medicare Quality Protection Act as one way of addressing these problems. If the bill is amended to make some of the clarifications suggested by the Society, ASIM believes that beneficiaries will be protected even further.

The Society also emphasizes that it believes it to be essential that adequate additional funds be appropriated to help finance the various provisions within the Heinz-Stark bill, particularly with respect to the PRO program. Many PROs have had difficulty meeting all the objectives in their contracts because of their limited finances. Their financial constraints have been exacerbated by the fact that in the last two years the Health Care Financing Administration has placed additional requirements on the PROs without adequately adjusting their finances to properly implement those requirements. Although the Society firmly supports peer review, and while ASIM strongly endorses many of the provisions within the Medicare Quality Protection Act, the Society believes that if the PRO program is expanded to a point that is not financially viable, then the health care of the beneficiaries will not be properly protected, the performance of the of the practitioners and providers will not be properly assessed, and the viability of the peer review program--and ultimately the Medicare program will be put in serious jeopardy.

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ASIM TODAY

The Impact of DRGs on Patient Care

A Survey by the
American Society of Internal Medicine
March 1984–October 1985

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BACKGROUND

Following implementation of Medicare's prospective pricing system in 1983, ASIM initiated a number of activities designed to familiarize internists with this new payment mechanism and to assess its impact on patients and hospital/medical staff relationships. ASIM recognized that the provision of quality patient care would take on even greater importance under a prospective pricing system based on DRGs, and, consequently, in March 1984, authorized funds for the design and distribution of a survey to evaluate the effects of DRGs on patient care.

ASIM's survey on DRGs and patient care first appeared in the March 1984 issue of The Internist (see Attachment A). Since then, it has been offered to members through the Society's newsletter and distributed at component meetings on an ongoing basis. The primary purpose of the survey is to evaluate the effects of the PPS system--both positively and negatively--on the quality of patient care. Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration (HCFA) any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

Although not a scientific survey, this project has successfully reached a substantial number of internists and elicited informative responses. As of mid-September 1985, 246 ASIM members, representing broad-based internists, subspecialists of internal medicine and neurologists, completed the survey. Many have submitted lengthy letters and case reports documenting specific instances where they believed DRGs had negatively affected patient care.

SURVEY RESULTS

The survey results are summarized below under five general areas: Quality of care, severity of illness, PRO review, changes in hospital practices/services, and hospital/medical staff relations.

1. Quality of Care

In its survey, ASIM asked internists whether they believed that the DRG system had improved the quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved and utilization review programs, improved communication among hospital departments). Only 24 of the 246 respondents noticed an improvement in the quality of care provided to Medicare patients. Moreover, there were over 200 specific reports of incidents in which internists believed the quality of care had been compromised as a result of DRGs.

The most common of these, reported by 105 internists, was the premature discharge of patients due to perceived DRG-related, hospital-imposed pressures. The following comments from individual internists are illustrative of many of those received:

> "Printed forms appear on the chart 1-2 days before the DRG expires strongly suggesting discharge."

> "The overall thrust of communications from the (hospital) administration is towards early, perhaps inappropriate, discharge."

> "When the DRG 'expires' I am reminded and urged to do something."

> "Pressure to discharge sooner is very great and workup is often incomplete."

Many internists also reported receiving daily updates or notices on how much their hospitals were losing as a result of certain patients. There were also indications that these pressures are being communicated to patients. As one internist commented:

> "One local hospital details the cost on the front of the record--the patient is aware of this. It has created anxiety . . ."

The remarks of other internists imply that the pressure many of them are experiencing to discharge patients earlier may be more indirect:

> "The hospital is not exerting pressure on our staff, but there is pressure just knowing the hospital's livelihood depends on us."

Many internists gave specific examples of the types of patients they believed were being discharged earlier than medically appropriate:

> "Alzheimer's patients without good placement."

> "Patients with pneumonia and abdominal pains."

> "Stroke patients have been transferred to inadequate intermediate care facilities because they had the first bed available."

> "Patient with prolonged problems with deep vein thrombophlebitis. (Another) patient with pneumonia went home before completing antibiotic course. Both patients were readmitted."

> "A post-cholecystectomy patient age 82 who had a collapsed vertebra, could hardly walk, and was not eating properly."

> "I could give you at least 50 examples already. Most patients were in the cardiac and chronic obstructive pulmonary disease (COPD) classes."

In a related question, internists were asked whether there had been any increase in patient mortality or morbidity associated with premature discharges. Some 47 respondents agreed that in their opinion early discharges had led to increases in patient mortality or morbidity, with many offering their specific impressions and experiences:

> "I feel so, at least two medical fatalities might have been avoided."

> "One patient with leukemia died at home three days after a premature discharge."

> "Definitely. A patient did not meet the criteria for further stay. He died a few weeks later."

> "Increased morbidity but not mortality as yet, although expected in the future since the hospital will get stricter in its evaluation."

Internists were also asked whether they had experienced any pressure from their hospitals to discharge patients and readmit them within the next few days or weeks, or were aware of instances where this had occurred. Eighty-one internists complained about hospital pressure to readmit patients shortly after discharge. Subsequent readmissions have two implications regarding quality of care, as evidenced by the responses. First, many internists stated that a large portion of these readmissions were the result of premature discharges: the patients were not strong enough to leave the hospital and suffered relapses. A gastroenterologist recalled one such instance:

> "EM, a 70-year-old black female, was admitted to the hospital and discharged one week later. She had diabetes, cholelithiasis, weakness, and difficulty in taking care of herself. Additionally, arteriosclerotic heart disease was a problem. She was dizzy and also had peptic symptoms.
>
> On the last hospital day after she was seen on medical rounds, she decided not to have a cholecystectomy. The hospital called my office and said since she had made the decision, and since she was a 'DRG patient,' 'can she be discharged?' Under those conditions and in spite of the fact that I felt she needed medical supervision and several days more in the hospital for general care, regulation of diabetes, and further assessment regarding gall bladder and cardiovascular problems, I agreed to the hospital's request.
>
> This was a mistake. She was readmitted to the hospital some 12 hours later having had a 'black-out' spell at home, which probably represented a transient ischemic attack.
>
> It was probably my error in submitting to pressure to get the patient out of the hospital earlier."

Secondly, regarding complicated hospital stays, internists reported that hospitals have been encouraging them to discharge patients and to readmit them at a later date for treatment of a second condition they had diagnosed during the first stay. As several internists reported:

> "We're advised if patients are found to have multiple problems, handle one major problem per admission."

> "Patients with multiple medical problems have one problem primarily dealt with per admission."

> "We are made well aware of the 'rules' encouraging this."

One respondent described a case in which a patient with old pulmonary tuberculosis and supporative bronchitis was diagnosed as also needing cataract extraction. After the patient's course of IV antibiotics, the hospital wanted her discharged and readmitted for cataracts. Another respondent spoke of a similar case but with a more drastic end: the patient was discharged, and kept out of the hospital for one week in order to be readmitted under a new DRG; the patient then died during the second readmission.

Finally, internists were asked whether they'd experienced pressure to underutilize medically necessary tests and procedures, and if so, to cite specific tests and procedures that they believed were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity. Only 35 out of a total of 246 internists responded affirmatively to this question. In fact, more internists (83) believe that DRGs have had the salutary effect of promoting a decrease in the ordering of unnecessary tests and procedures. However, a number of internists expressed concern that DRGs could eventually lead to underutilization of certain tests and procedures, to the detriment of patient care. In the words of one internist:

> "In my opinion, the single most important reason that 'unnecessary' tests are run is fear of lawsuits. When MDs can stop being afraid they will be sued if they miss some exotic, rare disease, they will stop ordering so many tests. I am afraid that the DRGs will pressure physicians to avoid tests because they aren't cost effective and legitimate diagnoses will be missed, leading to an increase in lawsuits. I think that one of the bad aspects of DRGs is that we cannot look for unusual disease entities because in general these searches are expensive and often nonproductive, and will be looked upon by PRO committees, etc., as inappropriate."

2. Severity of Illness

Internists were asked whether there were any DRGs they believed should be revised because they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degrees of patient illness, given the same diagnosis. Almost half of the respondents (102) indicated that changes needed to be made to either some or all of the 468 DRGs to adequately reflect variations in severity of illness. As one member summed up:

> "I feel the biggest problem seen so far is that the DRG is unrealistic--patients often have several diseases which need evaluation and/or treatment but DRGs relate to only one diagnosis. That means either poor care or cost overruns."

Of the DRGs specifically mentioned as needing revision, these cases were repeated most frequently: Guillian-Barre's syndrome, respiratory failure, myocardial infarction (MI), cerebrovascular accident (CVA), leukemia, chronic obstructive pulmonary disease (COPD), and stroke. The major complaint against the code for respiratory failure was that it does not allow for variations in condition and response. The DRGs for MI, CVA, and COPD lack flexibility to account for outside variables and complications.

Physicians stressed the need for severity classifications as some cases require more hospital days than others. Respondents complained about the inadequacy of the DRG for leukemia to pay the cost of services as it underestimates the necessary amount of care. Internists commented specifically on such inaccuracy:

> "The length of stay allowed for acute leukemia hospitalization is less than ten days, yet a course of remission induction chemotherapy typically requires 25-35 days."

> "Continuous IV infusion for seven to ten days is standard for a diagnosis of acute leukemia (DRG 404), and the DRG allows nothing for this or usual complications."

The DRGs for strokes presented problems because all strokes are, as one internist phrased it, "lump(ed) into a few simplified categories;" variations and complexities of strokes are not accounted for.

Some 75 internists reported experiencing pressure from their hospitals to upgrade the severity of diagnoses in order to maximize reimbursement. Respondents stated that many hospitals educate physicians through lectures and posted reminders to, for example, "seek more proper categorization to obtain maximum payment." Others reported that:

> "(We're) told to list all possible diagnoses so the best ones can be chosen."

> "There are DRG lists on all floors. The medical records people are always 'negotiating' our discharge diagnoses with us."

> "Diagnosis terminology is changed to fit the computer program. No change in 'severity'."

> "If you want to stay with the hospital you probably have to do that since the hospital is a business and the administrators always look at dollar figures."

3. PRO Review

Approximately 56 respondents stated that they believed the hospital's designated medical review agent (PRO or in the absence of a PRO, a fiscal intermediary) had increased its denial of medically indicated admissions under DRGs, to the detriment of patient care. As several members commented:

> "Dependence upon criteria is too strict."

> "Borderline cases are turned down, but usually are revised on appeal--MDs are more careful. But what about the patient who needed care but is borderline, as is the elderly man with pneumonia who lives alone?"

> "I am sure that some patients are not admitted because of possible denial."

> "I've had two patients denied despite the fact they needed admission, in our first three months of DRGs."

Some 45 internists also indicated that the PRO or fiscal intermediary had denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare.

4. Changes in Hospital Practices/Services

ASIM sought internists' views on whether the implementation of the DRG-based system has led to any decrease in the quality of services provided by hospitals such as (1) short staffing; (2) inappropriate substitution of nonbioequivalent generic drugs for brand name drugs; (3) a decision not to install a technologically advanced piece of equipment that has the potential to improve patient care; and (4) a decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere.

In response, 104 internists reported short staffing of, for example, nurses or lab technicians in their hospitals. They reported many lay-offs of nursing staff, resulting in increased paperwork and errors; decreased RN status and increased use of aides; decreased night coverage and delays in lab tests; and less nurses per patient. One internist reported not having "enough nurses to carry out tasks. A typical patient comment: 'I asked for a pain pill three hours ago."

Although not to as great an extent, ASIM members also noted the inappropriate substitution of non-bioequivalent generic drugs for brand name drugs (28 physicians); more decisions not to install a technologically advanced piece of equipment that has the potential to improve patient care (55); and decisions not to treat certain types of illnesses, or the encouragement of physicians to admit these patients elsewhere (43).

5. Hospital/Medical Staff Relations

A substantial number of internists spoke positively about hospital/medical staff relations. Three-quarters of the total number of respondents observed an increased awareness of medical costs among the staff. Some physicians commented that this consciousness of costs has heightened at the expense of quality care; for example, some argued that length of stay is shortened and the more costly and complicated tests are not implemented to the patient's disadvantage, or diagnosis/treatment of the more obscure illnesses is excluded. However, the general opinion is that this awareness is positive, as more physicians are becoming involved in various discussions and programs aimed at minimizing health care costs.

Forty-two respondents believed that the relations in general between the hospital and medical staff have improved. They've noticed increased participation and cooperation, and overall, better interaction between hospital and medical staff.

On the other hand, forty-two ASIM members complained about hospital efforts to identify and deny or restrict privileges to physicians perceived as "too costly." A more substantial number of respondents commented that although this has not been fully witnessed at this time, they can see such actions developing. Some have stated that the identification process--through so-called DRG profiles--has already begun, and that it is only a matter of time before outright denials are made by the hospital administration.

SUMMARY OF KEY FINDINGS

ASIM's survey results have documented both positive and negative experiences, opinions, and concerns of internists from across the country, and while anecdotal, provide some insight into the system's effects on physicians, patients and hospital/medical staff relations. As evidenced from the responses, many internists agree with the cost-saving potential of the prospective pricing system but are concerned that cost reductions will occur at the expense of patient care. Those responding to the survey clearly viewed pressures to discharge patients early as detrimental to the quality of patient care. This finding corroborated that of a study on DRGs conducted earlier this year by the General Accounting Office (GAO). The GAO found that patients are being discharged from hospitals after shorter lengths of stay and in poorer states of health than prior to DRGs. Many patients are being told improperly that they have to leave the hospital because their Medicare/DRG coverage has run out, according to the study.

Many internists responding to ASIM's survey recommended that adjustments be made to the DRG system so that it would better reflect variations in the costs of caring for certain patients. The average length of stay given in the Federal Register for each DRG was considered inappropriate for the following cases: Guillian-Barre's Syndrome, MI, CVA, COPD, leukemia, respiratory failure, and stroke.

FUTURE ASIM ACTIVITIES

ASIM will continue to survey members on an ongoing basis in an effort to evaluate the effects of DRGs on patient care. In addition to the ongoing survey, a more scientific survey will be conducted of a random sample of ASIM members. The Society will share these and future results with Congress, HHS, and PROPAC (Prospective Payment Assessment Commission), recommending changes to the system as appropriate.

The data received will enable ASIM to evaluate the system and propose any necessary changes. At this point, the Society has identified the major areas of concern and will continue further study in order to determine:

1. Whether or not the DRG-based system adversely affects the quality of medical care by limiting length of stay and results in the deterioration of the quality of hospital practices.

2. Whether or not DRGs decrease the accessibility of care by encouraging hospital review entities to deny certain admissions.

3. To what extent reimbursements are inadequate under the system and what the long term consequences are.

/srl
L-9001B

Total number of respondents--246

FOR INTERNISTS ONLY

Special Survey

ATTACHMENT A

How Have DRGs Affected Patient Care?

As all physicians know, a Medicare pricing system for hospital services based on diagnosis-related groups (DRGs) is now being implemented across the country, effective with the start of each hospital's fiscal year. This system is intended to encourage hospitals to become more cost efficient than has been the case in the past, and thereby to reduce the rate of increase in federal health expenditures.

ASIM is interested in collecting data with which to evaluate the effects of this system—both positively and negatively—on the quality of patient care. To do so, we need the help of internists—both ASIM members and nonmembers. If you are an internist or a subspecialist of internal medicine and have personally experienced any instances where the DRG system has affected the quality of inhospital care provided to Medicare beneficiaries, please complete the questionnaire below and return it to ASIM. To protect yourself and ASIM, please *do not* name or otherwise identify any patient; other physician; hospital, its management or personnel. Use generic terms only.

Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

There is no deadline for submission of this form since all hospitals are not yet under the DRG system; rather, we would like you to make copies, completing and mailing them to ASIM as the need arises. In addition, please feel free to make copies for other internists—ASIM members or nonmembers (e.g., in your practice or at hospitals).

Please answer the following questions based on your personal experience under DRGs, being as specific as possible in your response. Where appropriate, give examples of particular instances where the care of a patient has been affected, either positively or negatively. Including specific information related to each patient—age, sex, diagnosis, DRG assigned to the case, length of stay—would enhance the value of this questionnaire in establishing credible data with which to evaluate the DRG system. (Use additional sheets of paper as necessary.) PLEASE TYPE OR PRINT.

---

1. As a result of DRGs, have you experienced any pressure from your hospital to do any of the following—or been aware of instances where these problems have occurred (please check all those that apply):

☐ Discharge patients earlier than medically appropriate. (Please explain specific circumstances.)

105 responded affirmatively

☐ If so, has there been any increase in patient mortality or morbidity associated with premature discharges? (Please explain.)

47 responded affirmatively

☐ Increase short-stay admissions. (Please explain.)

48 responded affirmatively

☐ Underutilize medically necessary tests and procedures. (Please cite specific tests and procedures that you believe were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity.)

35 responded affirmatively

☐ Discharge patients and readmit them within the next few days or weeks. (Please explain.)

81 responded affirmatively

☐ Upgrade the severity of a diagnosis to maximize reimbursement (i.e., "DRG creep"). (Please explain.)

75 responded affirmatively

☐ Other. (Please explain.)

35 responded

2. Are there any particular DRGs you believe should be revised because, for example, they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degree of patient illness, given the same diagnosis? (Please explain, giving relevant DRG codes.)

102 responded affirmatively

3. Has the implementation of the DRG-based system led to any decrease in the quality of services provided by your hospitals such as:

☐ **Short-staffing (e.g., of nurses or lab technicians). (Please explain.)**

104 responded affirmatively

☐ **Inappropriate substitution of non-bioequivalent generic drugs for brand name drugs. (Please explain.)**

28 responded affirmatively

☐ Decision not to install a technologically advanced piece of equipment that has the potential to improve patient care. (Please explain.)

55 responded affirmatively

☐ Decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere. (Please explain.)

43 responded affirmatively

☐ Other. (Please explain.)

10 responded

4. Has the hospital's designated medical review entity (professional standards review organization (PSRO), peer review organization (PRO) or fiscal intermediary):

☐ Increased its denial of medically indicated admissions under DRGs, to the detriment of patient care? (Please explain.)

56 responded affirmatively

☐ Denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare? (Please explain.)

45 responded affirmatively

☐ Other. (Please explain.)

13 responded

5. Do you think DRGs have led to:

☐ **Increased cost awareness on the part of the medical staff? (Please explain.)**

183 responded affirmatively

☐ **A decrease in the ordering of unnecessary tests and procedures? (Please explain.)**

83 responded affirmatively

☐ **Improved relations between the hospital and medical staff? (Please cite specific examples.)**

42 responded affirmatively

☐ Efforts by the hospitals to identify and deny or restrict privileges to physicians perceived as "too costly?" (Please explain.)

42 responded affirmatively

☐ Improved quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved quality assurance and utilization review programs, improved communication among hospital departments, etc.)? (Please explain.)

24 responded affirmatively

Hospital Classification: ☐ **Urban;** ☐ **Rural**

Hospital Type: ☐ **Community (nonprofit);** ☐ **Private (for profit);** ☐ **Teaching;** ☐ **Other (please specify)** ______

Bed Size: ______

We have purposely left the responses anonymous to ensure greater candor in the replies. If you wish to identify yourself, however, please feel free to do so.

Internal Medicine Subspecialty (if any) ______

Date ______

PLEASE RETURN TO:

asim
american society of internal medicine
1101 Vermont Avenue NW Suite 500 Washington DC 20005

STATEMENT FOR THE RECORD
SUBMITTED BY THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE PATIENT PROTECTION PROPOSALS

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

June 3, 1986

The Blue Cross and Blue Shield Association, the national coordinating organization for all the Blue Cross and Blue Shield Plans, appreciates this opportunity to submit for the record our views on S.2331, the Medicare Quality Assurance Act of 1986. Today our Plans underwrite or administer health care coverage for 100 million Americans, including more than 20 million Medicare beneficiaries. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for most of the day-to-day administration of this important program.

S.2331, introduced by Senator John Heinz (R-PA), Senator David Durenberger (R-MN), and other Members of Congress is intended to respond to a number of concerns that have arisen with respect to the possible effects of Medicare reimbursement policy on quality of care. In particular, the bill would:

- Require HHS to develop a method for accounting for variations in severity of illness and case complexity in the PPS system, revise the notification and appeal procedures for beneficiaries, and prohibit certain hospital-physician incentive plans.

- Improve access to appropriate post-hospital care by requiring all hospitals to engage in discharge planning, making permanent the waiver of liability for skilled nursing facilities (SNF's) and home health agencies (HHA's), extending the waiver of liability for home health services to "technical" coverage issues such as the homebound and intermittent care requirements, directing that HHS develop an expedited review process for SNF and HHA claims, requiring a 24-hour response on beneficiary eligibility for post-hospital SNF care, and allowing providers to bring appeals on behalf of beneficiaries and to appeal "technical" denials.

- Improve review of quality of care by PROs by directing the review of early readmission cases and making other changes in the PRO program.

- Require a major two-year study that would assist in the development of a long-term strategy for quality assurance.

Quality Assurance in Hospital Settings

We strongly support the development of refinements to the Medicare prospective payment system to increase the accuracy, equity, and effectiveness of the system. Such refinements would provide reasonable assurance that the "winners" and "losers" under the constrained payment system reflect true differences in efficiency and not simply the result of imbalances in the system.

In particular, we support the development and implementation of a measure of severity of illness for the PPS system. We also support efforts to improve current procedures to assure that beneficiaries receive adequate notice and have adequate appeal rights with respect to the denial of benefits for inpatient hospital care.

Access to Appropriate Post-Hospital Care

We strongly support requiring that hospitals engage in discharge planning as a condition of participation in Medicare. Indeed, in the private sector working with hospital discharge planners is a growing component of the managed care programs that an increasing number of Blue Cross and Blue Shield Plans are administering for employers. Effective discharge planning can assure that patients receive adequate care after discharge as well as encourage the most cost effective delivery of such care. We recommend, however, that the required discharge planning functions be defined and implemented flexibly to minimize the burden on small and/or rural hospitals.

The bill includes a provision to broaden the "presumed waiver of liability" mechanism that home health agencies use to help mitigate the effects of unanticipated retroactive denials. That mechanism currently applies only to claims denials based on medical necessity and custodial care coverage requirements. The new provision would extend the presumed waiver of liability mechanism to the requirements that, in order for the services to be covered, the patient need skilled nursing care or certain therapies and the patient be homebound.

This provision is primarily a result of concern that these coverage requirements -- the homebound and intermittent care requirements -- have been implemented inconsistently across the country by fiscal intermediaries and that some intermediaries have applied them more rigorously than intended by the law. In our view, while the homebound and intermittent care requirements do result in some denials of care, those generally stem not from overzealous implementation of those requirements but the requirements themselves. As an intended response to the concerns that were raised, the

Congress included a provision in the Deficit Reduction Act of 1984 that required HCFA to designate ten intermediaries, rather than the current number of 47, to handle home health claims. To help ease the transition for home health agencies during the move to new intermediaries, the Comprehensive Omnibus Budget Reconciliation Act of 1985 provided that home health agencies would continue to be eligible for presumptive waiver of liability status under current rules for 12 months following the implementation of the regionalization.

We believe that most home health agencies are sufficiently familiar with Medicare coverage requirements to minimize the need for waiver of liability type mechanisms with respect to any coverage requirement in present law. However, we do recognize that elements of judgment necessarily enter into the claims determination process and that the directive to reduce the number of intermediaries will make it even more difficult for intermediaries to take into account the unique local circumstances surrounding a claim for home health coverage. We are, therefore, supportive of the extension of the waiver of liability to the homebound and intermittent care requirements to the extent that it will improve the predictability to providers of intermediary coverage decisions. We would note, however, that this provision is likely to increase Medicare benefit expenditures for non-covered care.

As mentioned previously, the bill would also require HHS to develop an expedited review process for claims submitted by skilled nursing facilities and home health agencies. Again, we would support such a requirement because it would help improve the predictability of the claims determination process. However, we would caution that for such a requirement to be effective adequate funding needs to be allocated to enable intermediaries to perform reviews in a prompt manner. In fact, current HCFA policy runs in the opposite direction. HCFA has directed contractors to increase overall claims backlogs in an effort to save administrative and program funds. We would, therefore, strongly urge that this legislation be coordinated with the appropriations process, and that funds be earmarked to improve the review process for post-hospital claims.

S.2331 also would expand Peer Review Organizations' (PROs) review of quality of care beyond the inpatient hospital setting. We would urge that this provision not be interpreted in a way that would disturb the Medicare coverage and utilization review process that intermediaries and carriers are now performing effectively and highly efficiently for post hospital institutional and ambulatory care.

We have not taken a position on the provision of the bill that would allow providers to bring appeals on behalf of beneficiaries and appeal technical denials. However, in reviewing these provisions, we believe that the fundamental issue is balancing due process considerations with administrative considerations. These changes would likely increase the number of appeals and their associated administrative costs. As indicated previously, the Medicare administrative structure is already strained to meet the current workload. It is also important to consider in a program as complex as Medicare whether beneficiaries need assistance in identifying and pursuing appeals of claims that have been denied.

Finally, we would like to suggest that you consider two other proposals in this area. First, we would urge that demonstrations of certain private sector approaches to the review of the appropriateness and cost-effectiveness of services be conducted under Medicare. In particular, we recommend demonstrations to test the feasibility and advisability of instituting a "prior approval" review process for the review of skilled nursing facility and home health admissions. In our private business, the pre-admission review of hospital services is an important and extremely effective component in our managed care programs. That experience could be applied to Medicare post-hospital care in a way that both improves the predictability of the process for beneficiaries and providers and helps assure that program funds are safeguarded. We believe that an effectively operated "prior approval" process may be a more appropriate long term solution to the problem of retroactive denials than continuing indefinitely the waiver of liability mechanism.

We would also suggest demonstration of "individual benefits management" under which an intermediary would consult with hospitals, SNFs and home health agencies, in conjunction with the patient and attending physicians, and approve payment for otherwise non-covered Medicare services where medically indicated, where appropriate to the beneficiary's needs, and where substitution of services would not result in additional costs to Medicare. Again, this is a mechanism that is used very effectively by a number of Blue Cross and Blue Shield Plans in their private business and may be appropriate for use in Medicare.

Second, we would urge greater attention to beneficiary and provider education. Such education could reduce the need to pursue appeals and help reduce the number of claims that are filed improperly. This relates to the funding issue, however, since beneficiary and provider communications activities are under severe funding constraints currently. In fact, unlike our private business, Medicare does not fund provider education programs at the intermediary level.

Study to Assist in the Development of a Long-Term Strategy for Quality Assurance

We strongly support this provision. There is a need for a thorough review of quality assurance from a reimbursement policy standpoint, from the perspective of the hospital conditions of participation and accreditation programs, from the claims and medical review perspective, and possibly from the perspective of patient outcome measures. Blue Cross and Blue Shield Plans, in their private business, are increasingly looking into this area as they develop PPOs and other mechanisms that encourage patients to use cost effective providers. In these efforts it is critically important to assure that such providers have adequate quality control processes in place and that appropriate external mechanisms, such as JCAH, act to periodically review quality of care rendered in individual hospitals. We would be pleased to participate in this study in any way we can.

Conclusion

In conclusion, we are encouraged by S.2331. It places needed emphasis on quality of care and establishes mechanisms to address a number of concerns that have been raised regarding Medicare policies and procedures relating to post-hospital SNF and home health care. We have suggested some further proposals that you might consider, and we would be pleased to help the Subcommittee as you pursue this issue.

**The National Association of
Private
Psychiatric
Hospitals**

1319 F Street, NW, Suite 1000, Washington, DC 20004 • 202-393-6700

June 6, 1986

The Honorable Bob Packwood
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the 240 private psychiatric hospital members of the National Association of Private Psychiatric Hospitals (NAPPH), I want to take this opportunity to share with the Committee the Association's analysis and recommendations regarding S. 2331, the Medicare Quality Protection Act of 1986.

It is our understanding that the Medicare Quality Protection Act of 1986 was an outgrowth of a 16-month investigation by the Senate Special Committee on Aging, which is chaired by Senator John Heinz, studying the impact of the DRG payment system on the quality of care provided to Medicare beneficiaries in hospital and post-hospital settings. Although it is clear that the intent of S. 2331 is to assure that the DRG payment system does not undermine the quality of care provided in hospitals and post-hospital settings, many of the provisions in the legislation would have a direct, or in some instances an indirect, effect on hospitals that are presently exempt from the DRG payment system. In light of this fact, NAPPH has reviewed S. 2331 and prepared an analysis of this legislation and its potential impact on private psychiatric hospitals and the patients we serve. Enclosed for your review and consideration is the NAPPH analysis and suggested refinements to the legislation.

I would respectfully request that this letter and the enclosed analysis be included in the June 3, 1986 hearing record on the "Quality of Care Under Medicare's Prospective Payment System". Thank you for your consideration of this matter. We look forward to working with you and the Committee on this legislation as it moves forward.

Very truly yours,

Bob Thomas
Robert Thomas
Executive Director

cc: Members, Senate Finance Health Subcommittee

NAPPH RECOMMENDATIONS FOR S. 2331, THE MEDICARE QUALITY PROTECTION ACT

I. Section 101--Severity of Illness Study

Provision: The Secretary would be required to conduct a study on the development of a patient classification system that reflects variations in severity of illness and case complexity.

* Require Department of HHS to make recommendations to Congress by January 1, 1988.

Recommendations: Clarify in bill that a part of the study should specifically deal with the severity of illness for psychiatric care. [Note: 49.6% of the Medicare psychiatric patients are presently carried under the psychiatric DRGs (e.g. scattered beds and non-exempt units.)]

II. Section 102--Inform Patients of Their Rights

Provision: Require the Secretary to develop a written statement that would inform patients of the following:

*patients rights to both inpatient and outpatient Medicare benefits;

*potential liability to the patient for charges of continued stay in the hospital;

*rights to appeal and appeal procedures;

*individual liability for payment if denial of benefits are upheld upon appeal.

Recommendation: Specify in the bill or report language that the written statement should include a sentence referencing the fact that a Medicare beneficiary has only a 190-day lifetime limit for psychiatric inpatient care in a freestanding psychiatric facility. This information would be especially important for a chronically mentally ill patient.

III. Section 105--Study on the Adequacy of the Conditions of Participation

Provision: Require a study on the adequacy of the Conditions of Participation regarding determining the quality of care in hospitals. Due within two years after enactment. Also, the committee report would state that the intent of the committee is to defer any changes in the Conditions that may affect quality of care until the study is completed.

Recommendation: The bill should require HHS to issue the revised Conditions of Participation as an interim final rule. If there is a new study mandated, it should focus on Subpart S (Certification Procedures for Providers and Suppliers of Services) of the Medicare Regulations which deals with the procedures utilized in implementing the Conditions. A study could also investigate various ways to strengthen "deemed status" for inpatient psychiatric facilities.

Finally, it is especially important to issue the new Conditions since these regulations contain sections on discharge planning which must not be held up for a new study.

IV. **Section 106--Study of Payment for Administrative Days**

Provision: Conduct a study on Administrative necessary days and if payments accurately reflect the actual costs of providing these services while awaiting placement in an SNF. This provision only applies to DRG payments.

Recommendation: Under the bill, only facilities participating in the DRG system would fall under the proposed study. However, facilities operating under the TEFRA limits also face similar problems in placing Medicare beneficiaries in other facilities. There should be a section of the study that specifically deals with administrative days for all hospitals under the TEFRA limits.

V. **Section 201--Require Hospitals to Provide Discharge Planning**

Provision: Require as a Condition of Participation a discharge planning process.

Recommendation: Discharge planning for psychiatric patients is an ongoing process initiated upon admission and continued throughout hospitalization. Periodically, the patient's needs for aftercare services are evaluated and discharge plans are developed in conjunction with the patient, family, and/or significant others. Such activities are often most appropriately conducted by the treatment team as the plan of care is developed and revised. This provision should not interfere with such practices by requiring new or distinct functions.

The specific recommendations dealing with the discharge planning provision follow:

(1) The bill or report language should clarify that the discharge planning process is an ongoing process throughout an individual's hospital stay and should not necessarily be separate and distinct from the overall plan of treatment.

(2) The physician should have discretion in whether or not the discharge planning evaluation should be made fully available to the patient based on the need to assure confidentiality of certain aspects of the evaluation.

(3) A hospital's policies and procedures should govern the type of health professional(s) most appropriate to develop the discharge planning evaluation rather than designating in statutes the specific professionals who must carry out this function.

VI. Section 204--Development of Uniform Needs Assessment

Provision: Require the Secretary to develop a needs assessment instrument that evaluates:

- functional capacity of an individual;
- nursing and other care requirements to meet health care needs and to assist in functional incapacities;
- social and familial resources available to the individual to meet those requirements.

Can be used by discharge planners, hospitals, nursing facilities, and other health care providers and fiscal intermediaries in evaluating post-hospital extended care services.

Recommendation: Psychiatric patients' needs are greatly different from the general health care needs of an individual. In determining the functional capacity of a mentally ill person, one must include the biological-psychological-social needs. Therefore, a separate needs assessment instrument should be developed for the psychiatric patient. NAPPH should be represented on the study's Advisory Board. NAPPH has submitted a research proposal to NIMH, which is pending before its Review Committee, to develop level of impairment indeces.

VII. Section 207--Provider Representation of Beneficiaries on Appeals

Provision: Providers would be able to represent beneficiaries in their appeals of Medicare coverage decisions and would allow providers and practitioners to appeal administrative or technical denials and any other denials of Part A claims.

Recommendation: This provision is critically important for the mentally ill patient because their illness in many respects hinders their ability to adequately represent themselves.

VIII. Section 208--Annual PPS Report to Include Information on Quality of Post-Hospital Care

Provision: The Secretary in each annual report to Congress on the PPS shall include an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under Medicare.

Recommendation: In reviewing the quality of care provided in a post-hospital setting for Medicare psychiatric patients it is not the procedures, but rather the non-availability of coverage and the lack of available resources necessary to meet the patient's aftercare needs. The Annual PPS Report should focus on the inadequate coverage for aftercare services under Medicare and the lack of community resources.

IX. Section 302--Requiring PRO Review of Quality of Care

Provision: Require PROs to review quality of services.

Recommendation: PROs are presently ill-equipped to review the quality of care in psychiatric facilities. They don't have the necessary level of expertise and/or resources. The quality of care review process in private psychiatric hospitals should be based on the type and nature of patients served by the hospital. The JCAH effort to establish clinical indicators should be encouraged and supported and quality of care criteria should not be set by regulation and based on a volume or numerical concept.

X. Section 401--Study to Develop A Strategy for Quality Review and Assurance

Provisions: Secretary shall arrange for a study to serve as a basis for establishing a strategy of reviewing and assuring the quality of care for Medicare-covered services. The study is due in two years after enactment.

Recommendation: The quality of care study should have a separate and distinct part on psychiatric care. A psychiatric quality of care strategy will most definitely have different components than a general health care strategy.

N

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July 3, 1986

COMMENTS ON S.2331
THE MEDICARE QUALITY PROTECTION ACT OF 1986

The National Committee for Quality Health Care respectfully submits the following comments to the Senate Finance Committee on S.2331, the Medicare Quality Protection Act of 1986. We request they be included with the June 3rd hearing record.

The National Committee for Quality Health Care is a coalition of health care companies including hospital providers, nursing homes, HMO's, manufacturers and professional firms which provide products and services to the health care industry. Our goal is to promote public policies which enhance both access to and the quality of our medical care system. The efficient provision of high quality medical care to our nation's elderly citizens is a goal of all our members.

Overview

The purpose of S.2331 is a laudatory one - to improve quality under the Medicare Prospective Payment System. This bill is intended to improve beneficiary protections and strengthen the monitoring of hospital practices. Many of the bill's provisions are designed to establish procedures to ensure that a process exists as a safeguard against the untoward actions of providers.

We believe quality problems related to PPS and Medicare beneficiaries to be limited in nature. The lack of widespread documented abuse supports this view. Nevertheless, systemic problems caused by piecemeal payment reforms and the resultant confusion of incentives are a concern to providers. Overall, despite the bill's objective of protecting quality, the National Committee doubts S.2331's provisions will ensure patient quality care. While we do not oppose all the bill's provisions, many are troublesome to us. In our view, the following actions would go much further toward improving overall quality care in Medicare without simply increasing the burden of regulation.

1730 RHODE ISLAND AVENUE, N.W. • SUITE 803 • WASHINGTON, D.C. 20036 • (202) 861-0882

First, mandate annual increases in DRG prices commensurate with actual hospital inflation rather than allowing inadequate payment updates by administrative fiat.

Second, encourage the establishment of a private accreditation system to oversee the provision of quality throughout a patient's spell of illness, not just in a particular setting.

Third, begin to the various levels of medical care delivery link through capitation or other prospective rate systems so that continuity is maintained.

Fourth, require additional studies of quality in capitated systems rather than continuing the narrow focus on quality of inpatient services.

Our comments on specific features of S.2331 are as follows:

DRG Refinements

We support the development of continued refinements in the DRG methodology including a severity of illness index. However, such refinements should not be proposed in lieu of reasonable annual updates of the standard DRG price. We would recommend that Congress amend the PPS statute to require an annual update based on the marketbasket for hospital goods and services. This change, perhaps more than any other, will ensure adequate resources to provide quality hospital services for all Medicare patients.

Beneficiary Notice

We agree that the current Patient Notice of Hospital Discharge Rights required by HCFA should be amended to inform beneficiaries of their rights to benefits of hospital and post-hospital services. We also agree that additional time for a beneficiary to appeal before a hospital may bill him for services is appropriate. These changes will better inform the patient of Medicare's benefits and provide ample time to appeal an early discharge.

In general, we are concerned that Medicare beneficiaries do not understand the complex benefit structure or administrative processes of the Medicare program. The entire Medicare program needs to be simplified so that our senior citizens know what services they are entitled to.

Physician Incentive Plans

The National Committee supports a provision which prohibits physicians from receiving direct monetary payments for discharging patients early. However, we are concerned that a broad prohibition regarding physician incentive plans may inhibit the move toward managed care programs. Prepaid health plans by their nature encourage physicians to provide the most cost effective care and as such limit inappropriate hospital admissions. Provider arrangements that emphasize patient management may lead to better quality care outcomes and should be encouraged, not restricted. The intent of the bill should be clarified so that only patient-specific incentive arrangements are covered. We believe the proposed study of additional sanctions of other physician incentive plans is unwarranted.

Discharge Plannng

The National Committee supports the bill's intent of improving hospitals' discharge planning process. The vast majority of hospitals currently operate discharge planning systems and have improved them since the establishment of PPS. We believe that the revised hospital conditions of participation recently published by the Department of Health and Human Services on June 17, 1986, are a prudent approach to this concern. These final regulations establish a new quality assurance condition of participation for hospitals. This condition requires a hospital-wide plan for overall patient quality management encompassing every facet of patient care. Under this new condition, discharge planning and social services both are made standards. This requirement should be sufficient to encourage hospitals to improve their discharge planning process. We understand that the Joint Commission on Accreditation of Hospitals (JCAH) requirements regarding discharge planning are equivalent to the Department's new regulations. Elevating the discharge planning process to a condition of participation and requiring the Secretary to establish detailed guidelines as proposed in S. 2331 is unnecessarily intrusive and will lead to added administrative burden without any added patient protection.

Uniform Needs Assessment

Development of a model patient evaluation system by experts in post-hospital care might be a valuable service to health care providers. However, there is no final answer, as methods for patient assessment are continually changing. Thus the application of such a model should not be mandatory. PROs requiring the routine use of such an instrument would be excessively burdensome, arbitrary for many, and would do little to improve patient care for most hospital patients.

PRO Quality Review

Various provisions in the bill expand the scope of PRO activity to include indicators of quality problems. We agree that the monitoring of such incidents and statistics may be useful. We also understand the PRO scope of work published by DHHS for next year strengthens and expands the PROs' quality-related duties in several ways. For example, PROs will now be monitoring several key quality indicators including nosocomial infection rates and readmissions within 15 days, among others.

The requirement that PRO review be extended to ambulatory settings, including HMOs, is inappropriate. PROs have had enough difficulty establishing viable hospital review programs without moving into still more problematic areas. COBRA already contains a provision mandating quality review of medical care for HMOs and CMPs entering risk contracts with Medicare. Assigning such reviews to PROs does not allow for the development of other private review organizations or accrediting bodies. Since medical review in the outpatient area is relatively new and untested, various private entities should be encouraged and allowed to undertake this review if they can do so responsibly.

Further Studies

With respect to additional studies on a quality assurance review strategy, the National Committee believes that studies currently underway and supported by HHS are sufficient to make recommendations in this area. If further study is necessary, it should be directed toward quality review in the area of prepaid medical care and capitation approaches. Further such studies should focus on private sector mechanisms and methods for ensuring ongoing quality review.

Summary

In conclusion, we believe the Senate Finance Committe has performed a valuable service by focusing attention on the potential effects of PPS on patient care quality. The Committee's findings and concerns have sent a strong signal to participating providers that inappropriate patient care activity will not be tolerated. Many of S2331's requirements are aimed at preventing future occurrences. While some of these changes could have a "sentinel effect" on providers, other provisions will divert attention and resources away from the primary mission of hospitals to provide the highest quality medical care. Moreover, many of the problems the bill seeks to correct are being addressed by regulatory requirements or administrative monitoring activities recently implemented by DHHS. Thank you for this opportunity to provide our comments on this bill.